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GENERAL VIEW OF ST. MARY'S HOSPITAL, DULUTH, MINNESOTA.

One Hospital's Monthly Summary and Analysis of Autopsied Cases

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THE month is a far better unit for hospital chart tabulation than is the year or any multiple thereof. The month is the time unit or basis upon which most people figure their wages or income; likewise the period which marks the influx of the average individual's routine bills and obligations. Careful doctors try to use it as the thirty-day cycle that automatically informs their patients of their medical indebtedness. In the same mail (we may casually remark) the doctor's contract with the telephone company, the building owners, the garage man, is put in such form as to escape the attention of no one except the pachyderm. And it is for the good of every one that it is so; the old yearly plan of adjustment and settlement would ruin any present day business.

The slightly modified chart of the American College of Surgeons here presented works out very well. It is usually the basis of the monthly staff meeting. If this sheet were enlarged to include a yearly tabulation, certain of the headings would be far too crowded. In any case, a yearly total, departmental or otherwise, is easily arrived at by simply adding up the various headings of the twelve monthly summaries. In fact, our record room shows on the wall a graphic chart, the lines of which are extended month by month to indicate all these totals at a glance.

OCTOBER, 1924, ANALYSIS OF HOSPITAL SERVICE ST. MARY'S HOSPITAL, DULUTH, MINN.

Hospital Patients

Remaining October 1, 1924	200
Admitted	485
Births	56
Total	741

Patients Discharged

	Med.	Surg.	Ped.	Total
Cured	27	100	5	132
Improved	87	62	18	167
Unimproved	5	2	0	7
Deaths Inst.	8	9	4	21
Deaths 48 hours	2	5	1	8
Tonsil Cases		107		107
Adm. for diagnosis	16			16
Labor Cases				55
New Born				51
New Born Deaths				3
Still Births				1
Remaining November 1, 1924				173
Total				741

Diagnoses

	Med.	Surg.	Ped.
Agree	103	136	20
Disagree	4	5	0
Additional	20	36	7
No working diagnosis	0	0	0
Admitted for diagnosis	19		

Operations

(a)	Major	88
(b)	Minor	34
(c)	Transfusions	2
(d)	Radium	1
(e)	Tonsillectomies	107

Deliveries

(a)	Normal	34
(b)	Instrument	14
(c)	Version	4
(d)	Breech	2
(e)	Cesarean Section	1
	Total	55

Infections

Institutional		On Admission	
Surgical	4	Surgical	16

Deaths

		Autopsies	
Medical	10	Medical	6
Surgical	14	Surgical	6
Pediatrical	5	Pediatrical	5
Obstetrical	0	Obstetrical	0
New Born	3	New Born	0
Still Born	1	Still Born	0
	33		17
Dead on adm.	2		
Emergency Cases			40

(Dressing room chiefly)

Unimproved

90443	Carcinoma of Stomach with Metastasis	1
90647	Cholecystitis and Nephritis	1
90448	Dementia Praecox	1
90028	Sarcoma of Spine	1
90894	Migraine	1
90838	Typhoid	1
90690	Carcinoma of Abdomen and Pelvis	1
	Total	7

Consultations

Medical	17
Surgical	28
Pediatric	2
Obstetric	1
Total	48

Autopsy Tabulations and Remarks

The following statement of the autopsies, with pre-autopsy diagnoses, is presented for various purposes which will appear in the brief discussion accompanying the data. Dependent upon features contained, comments are found bearing upon the case; obvious oversights, terminology, the contrast between physiological perversions and anatomical and pathological defects.[1]

Note the extreme youth of this individual, showing the essentially rare location of the aneurysm as compared to its usual site within the thorax. This chart in review received some criticism, not on its character and completeness; rather because the pulsating mass within the abdomen was explored with the presumptive diagnosis of an aneurysm, but no thought of "wiring" had apparently come up. It was thought and suggested that the patient might have been a case where this could have been used with advantage.

Clinical Diagnoses	Autopsy Diagnoses
1. No. 90194. Surgical. Aneurysm of the abdominal aorta. Admitted 9/2/24; died 10/7/24. Male, aged 32, married. (A pulsating abdominal tumor had been explored by operation three weeks before death.)	Ruptured aneurysm of abdominal aorta. Hypertrophy of the myocardium. Fibrosis and fatty changes of the myocardium. Erosion of the lumbar vertebra. Scars at right apex—fibrous, pleuritic adhesions. Multiple traumatic scars over body. Chronic nephritis. Hypoplasia of the genitals. Emaciation Grade I.
2. No. 90540. Pediatric. Acute nephritis. Lobar pneumonia. Suppurative rhinitis & sinusitis. Admitted 9/22/24; died 9/29/24 Male, aged 8, single.	Acute glomerulonephritis. Tonsillitis. Edema of neck, larynx, face, eyelids. Hydrothorax, hydropericardium, ascites. Multiple hemorrhages of pleura, pericardium, peritoneum, bladder, stomach, eosophagus, larynx, trachea, and thyroid. Emboli of the pulmonary artery. Multiple infarcts of the lungs. Congestion of the liver. Acute myocarditis. Acute splenitis. Struma diffusa colloids. Hypertrophy of the left and dilatation of the right heart.

Marriott of St. Louis, and his associates, should have credit for drawing particular attention to the role played by sinus infection in serious systemic infections and toxemias in children. Particularly is there this notable association between this type of early invasion and later nephritis.

Note also in this instance the widespread edema, bespeaking the common association of a nephrosis with the nephritis. Many pathologists seem to dislike the attempt of clinicians to differentiate the nephritides and the nephroses. It is certain that most of the acute albuminurias are the latter, and there are a few pure chronic nephroses. It is likely that no acute nephritis exists in which the damage is all glomerular and in which there is not some tubular degeneration.

3. No. 90698. Pediatric. Acute diffuse nephritis. Admitted 10/2/24; died 10/5/24. Male, aged 2 years. (The nephritis had begun to improve for a time. Then an exacerbation occurred, followed promptly by death.)	Acute glomerulo-nephritis. Hypertrophy of the heart. Hemorrhages of the endocardium. Edema of the lungs. Ascites, hydrops of the pleurae and of the pericardium. Edema of the face, of the mediastinum and of the scrotum. Struma diffusa colloids.

[1] It should be stated that the autopsy diagnoses have been left quite unchanged as designated by the staff pathologist, Dr. G. Berdez, graduate of the Swiss University of Lausanne, and former pupil of Aschoff. The reader will recognise the imprint of European teaching. Nevertheless, Doctor Berdez's American experience has included six months with Dr. H. E. Robertson of the Mayo Clinic.

Here again we have the same sort of situation as in the autopsy just reported. The attending physician was not so sure of just what sort of infection originated the process, since he was called when the child had considerable edema and an obvious nephritis.

4. No. 90982. Pediatric.
Acute laryngitis.
Admitted 10 / 21 / 24; died 10/27/24.
Male, aged 2 years.
(The child had been intubated on the basis of a possible diphtheria in the presence of obvious obstruction.)
Laryngitis acute.
Status after tracheotomy.
Broncho-pneumonia.
Interstitial emphysema of lungs.
Dilatation of the heart.
Adenoids.
Hypertrophy of the tonsils.

This child began with an upper respiratory infection, producing edema, evidently of the glottis and adjacent parts. It is likely that if more time had been available or the child seen sooner, the preliminary intubation might have sufficed. Cultures proved the condition to be non-diphtheritic. The interstitial emphysema would appear to have been due to alveolar trauma incidental to laryngeal stenosis.

5. No. 91041. Pediatric.
Athrepsia.
Admitted 10 / 25 / 24; died 10/26/24.
Female, aged 4 months.
(This premature infant entered the hospital in extremis.)
Prematurity.
Stenosis of the aorta.
Interstitial emphysema.
Chronic enterocolitis.
Hypertrophy of the left ventricle.
Hemorrhages of the lung.

It would appear that this child was not only premature but that there were considerable anomalies. It is difficult to harmonize the condition of stenosis of the aorta with hypertrophy of the left ventricle. At least the type of hypertrophy seen in adults, associated with aortic stenosis, is the "concentric" type, giving a globular heart, due to thickening of the wall, rather than an enlargement of the cavity of the left ventricle.

6. No. 90587. Surgical.
Acute appendicitis.
Admitted 9/24/24; died 10/4/24.
Female, aged 7 years, single.
(Patient entered the hospital with evidence of peritonitis and an indefinite right sided complex suggesting the appendix.)
Fibrinous pleuritis of left pleura.
Beginning pneumonia.
Edema of the lungs.
Dilatation of the heart.
Peritonitis.
Status after appendectomy.
Enteritis catarrhalis.
Cloudy swelling of the liver and kidneys.

This was not one of those rather common instances where a surgeon's zeal led him to operate upon a child for appendicitis on account of abdominal signs in the presence of a developing pneumonia. The case was carefully studied, and operation was urged by the pediatrist. A doubtful appendix was found (only moderate signs of inflammation commensurate with that involving the nearby intestine.) On the other hand, a very definite thickening and edema of about ten inches of the ileum was found close to the ileo-cecal valves. At this point the lumen of the gut was considerably dilated, much of the intestine deeply congested, and suggested to the surgeon that a widespread enteritis existed. The further course of the infection was widespread, as indicated by the pathologist's headings. The chart was criticized notably because neither at operation nor at autopsy, had careful cultures been made to identify the organism. The course, however, did not suggest the ordinary "pneumococcic peritonitis."

7. No. 90995. Medical.
Hemorrhage from stomach (Ca?).
Admitted 10 / 22 / 24; died 10/29/24.
Male, aged 63 years, married.
(This man worked up to a very few days before he entered the hospital.)
Tumor of the stomach, carcinoma.
Hypertrophy of the prostate.
Anemia Grade III.
Old pleural adhesions.
Scar of the right apex.
Calcarious hilus gland.
Arteriosclerosis Grade II of the aorta, coronaries, aortic valves.
Arteriosclerotic kidneys Grade I.
Fatty change of the liver.
Struma nodosa colloides.
Chronic splenitis.

It is evident that this patient had rather extensive arterial disease, and the common association of prostatic enlargement. The apparently silent cancer in the stomach is by no means unusual. The strong adherents to the theory of pre-cancer lesions, and specifically those who look on every *gastric* ulcer as the "beginning of their cancer," do not get much support from instances like this. No doubt gastric ulcers may also be silent, but it is notable that Crile of Cleveland has recently spoken, after visiting a number of the surgical clinics of Europe, notably in the Scandinavian countries, Denmark and Holland, stating that in these countries they were not much impressed with the idea that most gastric cancers are preceded by ulcer. Neither is it usual for such copious hemorrhage to result from cancer of the stomach. More often such hemorrhage is likely to be due to ulcer or cirrhosis of the liver. This shows, however, that cancer may result even in fatal bleeding.

8. No. 90965. Medical.
Pneumonia.
Admitted 10 / 20 / 24; died 10/21/24.
Female, aged 64 years, widow.
(Patient was seen in extremis, and very little clinical study had been given her.)
Chronic endocarditis — mitral stenosis, aortic stenosis; relative insufficiency of the tricuspid.
Hypertrophy of the left and right ventricles.
Dilatation of the cavities of the heart.

It is most interesting here to note how easy it is in terminal states to confuse pulmonary and cardiac disease. There is little or no history, probably through no one's fault. This is so true of a large number of records where complete autopsy findings have uncovered and deciphered interesting pathological sequences. From the vast storehouses of medical literature and teaching, many accurate deductions are possible. (For example, here, it is more than a likelihood that this patient at some time or other had a rheumatic infection or its equivalent; the sequence of events with ultimate tricuspid failure, and the development of a so-called "Pick's cirrhosis" are typical enough.) Nevertheless, as doctors are induced to keep better records over longer periods of time, not only are the autopsy cases in that community going to teach more and assist in making our clinical deductions represent more accurately, pathological entities, but the pathologist also learns to vivify his report; he makes it represent something more of a

RECORD ROOM, ST. MARY'S HOSPITAL, DULUTH, MINN.

schedule of successive changes and less an enumeration of those obtaining at the time of death.

9. No. 59242. Medical.
Cerebral thrombosis.
Atherosclerosis.
Admitted 6/2/24; died 10/24/24.
Female, single, aged 54 years.
(Patient entered the hospital after a cerebral accident, from which she never recovered.)
Emboli pulmonary artery.
Broncho-pneumonia.
Coronary sclerosis, Grade III.
Arteriosclerosis aorta, Grade III.
Atrophy of liver.
Stasis of liver.
Fatty degeneration of liver.
Chronic cholecystitis.
Struma nodosa colloides.
Edema, ankles.

It is likely that in no field of our endeavors does a lack of common nomenclature create more confusion than in the all important field of arterial disease. Allbutt has succeeded in bringing the term "atherosclerosis" into rather common use. If we depart from a consideration of the blood vessels themselves to the various tissue changes in such important organs as the brain, the heart, or the kidneys, we note at once that confusion becomes doubly confused. It is commonplace to hear a discussion in which it is evident that in the speaker's mind the term "arteriosclerosis" covers verily a multitude of pathological possibilities!

Many minds automatically rebel at dissociation and classification, and yet these processes are vital if we are to keep ahead of osteopathy or other loosely guided cults. The end result may be the same in a considerable number of conditions, but the length of time involved, the age incidence of events, may vary greatly, and the report of the necropsy may give no inkling of some of the most interesting features. For example, this relatively young woman (for such widespread arterial decay) was very well known to the writer. She was an excellent practical nurse; a most sturdy and vigorous Scandinavian woman, who seemed at 35 to be absolutely tireless and superendowed. Two known factors certainly hastened her decline: (1) persistent and numerous attacks of tonsillitis—she did not have her tonsils removed until about six years ago—probably after a great deal of damage had been done; (2) emotional strain and shock; for nearly twenty years she took care of a heavy woman, who gradually became absolutely helpless with arthritis deformans. Every sharp pain and every sleepless night registered a wound in the very soul of this most faithful attendant—the kind the pathologists do not find, even though they frequently never heal!

10. No. 90669. Medical.
Bronchopneumonia.
Admitted 9-30-24; died 10-3-24.
Female, married, aged 27.
(This patient also came in in extremis after a confinement in the home, concerning which little is known.)
Chronic nephritis.
Status puerperalis.
Pneumonia (bilateral).
Edema of the lungs, of the ankles, of the vulva, of the intestine.
Ascites, hyropericarditis, hydrothorax right.
Sero-fibrinous pleuritis left.
Hypertrophy of the left ventricle.
Fibrosis of the myocardium, Grade II.
Arteriosclerosis, Grade I, of the aorta, coronaries.
Fatty change of the myocardium, of the liver, of the pancreas.
Struma diffusa colloides.
Emaciation, Grade II.

Damage to the blood vessel system is possible very early in life; note here, moreover, that the condition of fibrosing myocarditis may arise early also. In general, note in these autopsies the frequency of colloid goiter, since this is well known to be an endemic goiter region.

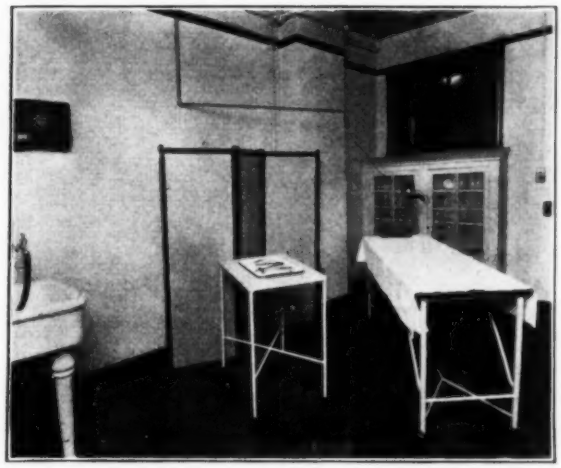
11. No. 90486. Surgical.
Cholecystitis.
Cholelithiasis.
Admitted 9/29/24; died 10/4/24.
Male, married, aged 64.
(This was an instance of recurring jaundice with ultimate colic and a marked chill, indicative of cholangitis, in a man with evidence of myocardial weakness.)
Status after cholecystectomy, appendectomy.
Localized peritonitis.
Old inguinal hernial sac.
Fibrous adhesions of small intestine.
Hemorrhagic infraction and beginning necrosis of small intestine.
Embolus of the portal vein (partial).
Polycystic kidneys.
Dilatation and fibrosis of the heart.
Chronic pancreatitis.
Obesity, Grade II.

The surgeon in this case, in staff meeting, was criticized because he ventured under difficulties and many adhesions, to do a cholecystectomy instead of simple drainage. It was pointed out that the peritonitis was very local and had no bearing upon the ultimate issue, but that the interference with the portal system did.

The liver presently is the center of a clinical offensive which we hope profoundly will deliver to us functional[2] evaluations comparable with those we have now for the kidneys and the heart. Certain it is that the liver is not an innocuous and innocent bystander!

12. No. 90891. Medical.
Purpura hemorrhagica.
Admitted 10/15/24; died 10/18/24.
Female, single, aged 18.
(This patient entered the hospital after
Anemia, Grade IV.
Purpura with hemorrhages of the skin, nose, lips, pericardium, pleura, peritoneum, ovaries, stomach, intestine, endocardium, bronchial and uterus mucosa.

[2]The phenoltetrachlorphthalein test as originated by Rowntree and perfected by Rosenthal and others, is promising.



NECROPSY ROOM, ST. MARY'S HOSPITAL, DULUTH, MINN.

having been treated for several days by an E. E. N. & T. staff member for persistent epistaxis from the customary erosion on the septum. Suddenly she developed extreme purpura, against which the customary calcium and blood transfusions at the time given were unavailing.)

Hemorrhagic infarction of right auricle.
Fatty change of the myocardium, liver, kidney.
Empyema of the lungs.
Calcified foci in the hilus glands.
Arteriosclerotic changes, Grade I, of the aortic and mitral valves.
Red bone marrow in the diaphysis of the femur.

Much staff discussion followed this report. Too many segmental specialists fail to function as far as the eliciting or cataloging of the history is concerned. It was found, when too late, that this girl had been having menorrhagia for many months, and had from time to time these purpuric spots over the body, but only came to the doctor to have the nosebleed stopped. Interestingly enough, he had stopped this for her on two or three occasions before. During her stay in the hospital she had two counts made of the blood platelets, and there was a distinct diminution. The bleeding and clotting time were both greatly prolonged, but the test involving the adherence of the clot to the side of the test tube was not made.

In view of the recent cases reported from the literature and from the Mayo Clinic by Giffin,[3] it is possible that if she had been studied earlier she might have been one of those cases, severe in character and intractable, for which splenectomy has been found to yield a symptomatic cure.

This chart, instead of reflecting upon the essential intelligence of men practising within limited specialties, simply emphasizes the fact that every practising doctor must know a good deal about current medical literature and progress, and even an eye, ear, nose and throat man must remember that the spleen is retained even when the nasal septum is removed!

[3]Giffin, H. Z., and Holloway, J. K.—Hemorrhagic Purpura. M. Clinics N. America, 7:241-8, July, 1923. Thrombocytopoemia and Splenectomy (as yet unpublished proceedings. Minn. State Med. Soc., October, 1924).

13. No. 90515. Surgical.
Diabetic coma.
Admitted 9/21/24; died 10/3/24.
Female, aged 60, married.
(This patient died in diabetic acidosis despite insulin and various other measures. "Emaciation — great degree" — was decisively evident.)

Fibrinous pericarditis.
Dilatation of the heart.
Fibrosis of the myocardium.
Arteriosclerosis, Grade IV, of the aorta, of the coronaries.
Arteriosclerotic kidneys, Grade II.
Old fibrous pleural adhesions.
Thrombosis of the aorta, abdominalis.
Acute splenitis.
Multiple cysts of the kidneys.
Status after laparotomy, and after old extirpation of the left tube and ovary.
Edema, Grade I, of the ankles.
Emaciation, Grade III.
Atrophy of the pancreas.

Now that we know that diabetes is fundamentally and essentially a pancreatic deficiency, the findings in these cases become of greater interest, particularly as they show pancreatic change.

This patient would have to be cataloged as one of the severer grades of the "arteriosclerotic group." For long periods she had a tolerance without insulin to guide her fairly well, but for many years she had treated herself very badly and must have carried high blood sugars most of the time. She had been treated in several diabetic clinics, and insulin, when she took it correctly, had given her extra energy through greater food intake. It probably led her, however, to overdo, and her final undoing came about through an enteritis, the aftermath of a rather long automobile trip and badly chosen food.

Grossly, the pancreas was described as "about a third of the usual size, the cut surface and markings fairly normal — the pancreatic duct undisturbed." Under the microscope there was reported "a moderate and diffuse increase in interstitial connective tissue * * *. There were some areas of lymphocytic foci, and in these areas the glandular elements show atrophy * * *. There appears to be no decrease in the relative number of the islands of Langerhans in the tail of the organ, but in the head they are relatively scarce. Their general structure is rather compact, and their capillaries contain relatively little blood, and the connective tissue increase about them in the head of the organ is more marked than in the tail. Several small arteries show marked thickening of the intima."

This appears to confirm the contention that atherosclerosis gradually accomplishes and brings about pancreatic insufficiency.

14. No. 90840. Surgical.
Direct inguinal hernia.
Admitted 10/12/24; died 10/13/24.
Male, aged 27, divorced.
(Patient was operated upon under general anaesthesia [ether]. He died upon the table just about the time the operation was finished. Death was very sudden, and efforts at resuscitation futile.)

Persistent thymus (status thymicus).
Edema of the lungs.
Status after herniotomy.
Old fibrous pleural adhesions.
Fibroma of the endocardium of the right ventricle.
Slight fibrosis of the myocardium.
Arteriosclerosis, Grade I, of the aorta coronaries.

No fault could be found with the manner in which this patient was prepared; neither was it at all likely that any criticism could be leveled either at the surgeon or the anaesthetist. It brings up the old and much mooted question relative to the malign influence of persistent thymus in *some people*. There was not shown here at autopsy the tendency to general glandular enlargement or petechial hemorrhages so often seen in children—the victims of sudden death after acute and often trifling infections.

The surgeon stated that the man seemed too averse to the idea of a local anaesthetic to press the matter strongly, or urge it against his will. Would the enthusiast for local anaesthesia be correct in intimating that he would have been any safer with a local anaesthetic?

These and many other questions arise whenever we carefully scrutinize our work. It has been by no means easy to cull out these few fragmentary ideas from three sources all within my grasp: the clinical records and hospital charts; the pathologist's very full necropsy reports; my own working knowledge of medicine. I hold all three to be equally faulty in arrangement of ideas if not obvious errors. Nevertheless, case histories are never going to be perfect and complete, and if they ever became so, autopsies would be unnecessary. My working knowledge of medicine is never going to satisfy me, and I therefore humbly beg my medical readers to rescue me from this thraldom of "kindergarten" medicine by publishing in this Journal some of their own cases and autopsy summaries.

The Hospital and the Catholic Home

Edward F. Garesché, S. J.

THE constantly increasing tendency among our American folk is to come to the hospital for treatment or diagnosis even in sicknesses which in former times were treated at home. In this way all the members of a family may from time to time become inmates in a Catholic hospital.

While they are patients there they offer exceptional opportunities to the hospital personnel to influence and help them for the better. This kindly aid may be given not only in what concerns their bodily health and vigor, but even more for their spiritual and social benefit. The ailment for which they come may be completely cured while they are at the hospital, and they may be discharged in general good health. But their home life and their general spiritual well-being are constantly capable of improvement. Through the influence of the hospital they may be instructed, helped, advised, and brought to take a greater interest in their own souls and the spiritual welfare of those dependent on them.

Spiritual and Social Work

No one will say that this salutary instruction and influence is no business of the Catholic hospital. Catholic hospitals exist no less for the benefit of the soul than of the body. In point of fact, our good Sisters are often consoled for their sacrifices and labors in the hospital chiefly by the fruit they see, and the still greater fruit they can conjecture, which comes to the souls of those who are ministered to within their walls.

A greater objection to widening the activities of the hospital in this regard is to be found in the fact that the mere bodily care of patients demands so much effort and energy that systematic measures for their spiritual and social care are difficult to manage. But even from the viewpoint of the hospital itself it is amply worth while to attend to these latter activities. While the perfect physical care of patients redounds greatly to the credit and benefit of the Catholic hospital, their spiritual care brings it almost as much advantage.

This is especially true of those hospital activities in spiritual and social work for patients, directed to the improvement of the Catholic home. The atmosphere of Catholic homes, or to be more exact, the Catholic atmosphere of homes, is of paramount importance in fostering and encouraging vocations. Therefore, hospitals which strive to have an influence on the homes of their patients through religious and social work, are promoting their own best interests by securing for themselves in the future, more devoted labors in the ranks of their own Sisterhoods.

The Home and Vocations

Of all the means of fostering vocations, the most effective, perhaps, is that of encouraging in Catholic homes a supernatural spirit of fervor and self-sacrifice which will give children who are called by God to the religious life, the requisite dispositions of mind and heart to answer to that call. God always does His part in giving grace and opportunity to all of those whom He wishes to enter religion. It is the weakness of the human will which hinders the following of vocations, and this weakness is most often brought about by worldliness and by the lack of that spirit of self-sacrifice which alone can serve as an effective counterpoise to the selfishness and self-seeking of the human heart.

Such a spirit of self-sacrifice and of supernatural faith and devotion can best be cultivated in a Catholic home. Even our schools often strive in vain to inculcate this deep Catholic spirit in their pupils, if their efforts are counterbalanced by unworthy conditions in the homes from which those pupils come. Homes without Catholic reading, Catholic conversation, or religious atmosphere, are effective hot-beds of worldliness. Although their children may not go far astray and may keep in communion with the church and remain faithful to her teaching, still they will hardly have the courage and the deep realization of their Catholic faith required to induce them to leave all and follow Christ.

Making Friends for the Hospital

Even in the case of those who have no religious vocation, the hospital will consult its own great interests as well as the general interests of the church, in striving to make them more fervent Catholics and to strengthen the Catholic atmosphere of their homes. There is a continual reaction between the hospital and the patient. Those patients who have been influenced for the better in their religious life, feel more lively gratitude to the Catholic hospital and are more certain to patronize it again when they next have occasion for diagnosis or treatment. They will be more generous in responding to appeals for funds or other cooperation to improve the hospital. In a word, the better Catholics they become through the hospital, the better friends they will be, of the hospital itself.

When one considers the general interests of the church, the preciousness of the hospital's influence on the home becomes even more evident. We live in a time when Catholic homes are at a decided disadvantage. They are invaded by worldliness in insidious forms. Commercialized amusements of a dubious character, villainous literature, too great liberty of conduct, play havoc with many homes. The hospital can counteract these things to a certain degree by its influence. Indeed it has a much greater potency in this regard than many workers in Catholic hospitals seem to realize.

True, patients in hospitals who are struggling for life, who come to the rooms or the wards prostrated with disease, or in the immediate need of an operation, are not fit subjects for very extended instruction. They may be brought back to their duties and indeed be in excellent disposition for this sort of religious influence, but that stage of their hospital experience does not lend itself to much social or religious activity.

The Interested Patient

We must remember that only a certain group of hospital patients are in this immediate stress or danger. There are always a considerable number who have passed the crisis of their disease, or are recovering from their operations, and who actually crave for some form of interest and occupation. They will listen to whatever the nurse or Sister suggests in the way of social or religious betterment. They will read whatever is given them and remember it because it is in some way linked with the memorable experience of their convalescence. They are more impressionable than at other times, are more docile, and they have, besides, the added incentive which comes from their realization that God has been good to them in bringing them safely through their illness or operation.

Some definite measures are, of course, required to take advantage of this opportunity. To help patients effectively in their social and religious life, and especially in their home atmosphere, distinct effort is needed. Yet when once this branch of hospital service has been realized and organized, it will go as smoothly as any other department and require much less extra activity than the introduction of a new department in any other line. Both Sisters and nurses are continually talking with convalescent patients. It only needs some definite purpose on their part, with tact and prudence in making suggestions, to enable them to prepare the patient for more effective spiritual and social action when his hospital days are over.

The Influence of Books

A copious supply of the right sort of books will play a prominent part in this effort. Catholic books in the hospital should, we repeat, be convenient everywhere. The convalescents will be reading, and it rests in large measure with the hospital authorities to determine just what books will be chiefly read. They may promote an interest in certain books by supplying them abundantly. Generally speaking, the patient will read whatever is nearest at hand if it is reasonably attractive. By putting in his way just at the right time and in the right place, the sort of books he wishes to peruse, you may be sure he will look at them.

A book is its own silent recommendation. Merely to bring a book into the patient's room and leave it on his table is to invite him to read it. The book speaks for itself. A great part of promoting Catholic reading is the mere physical effort of getting the right book in the right place at the right time, just as a great part of practical dietetics is supplying the right food under the right circumstances. The supervision of this systematic circulation of the right book should be entrusted to some definite person, but every one can share in the work. It will be well to have some one chiefly responsible, to ensure perseverance.

Supplementing Physical Services

Catholic book lists may also be given to patients and they may be impressed in every-day conversation with the need of having well selected libraries in their own homes. This one thing will go far toward promoting the Catholic atmosphere. Besides, the hospital personnel and especially those who have to do directly with the sick, will do well to keep in mind the influence their remarks may have upon the patients in the way of encouraging them in their religious duties and interesting them in the Catholic atmosphere of their homes in general. This may be done in the course of ordinary conversation. From the fulness of the heart, the mouth speaketh, and those hospital workers who have thought about conditions in Catholic homes and are zealous for the spiritual welfare and social progress of the patient, will not find it difficult to make the proper remarks at the right time.

In the multiplicity of hospital organization, it is profitable to call attention from time to time to these important activities which otherwise might run some risk of being relatively neglected. The bodily care of the patient is the hospital's first responsibility and must be attended to by all means. Yet these social and religious influences beautifully supplement the corporal

work of mercy, of nursing the sick. They offer to hospital workers a certain relief from sometimes wearisome preoccupations with the poor, suffering body in their care. They form a spiritual work of mercy; one very pleasing in the sight of Him to whose principles and service all Catholic hospitals are dedicated. They bless like Portia's quality of mercy, both him who gives and him who takes.

The Nurse's Training in its Relation to Preventive Medicine[1]

Louis D. Moorhead, M.D., Dean, Loyola University School of Medicine, Chicago.

SOME time ago there died in the city of Chicago, a man whose passing caused a stir in the busy humdrum of the city's life. He had lived his full years, and was beloved and respected by many. As I turned away from the grave after paying a last tribute of love, honor, and respect to my departed friend, what were my thoughts?

Were they fixed upon the titles he had attained in life? Did they consider the heights he had reached in the business and financial world? Did they contemplate the vast wealth he had left behind him? No. None of these was worthy of consideration then. They were too trivial, too unimportant. One's thoughts were concerned not with what he had obtained from life, but with what he had given life; the service he had rendered, the influence that had been his, and the influences that still remained; whether his contacts in life were better because of his association, or had suffered because of his society.

And what was the conclusion that was borne down upon me from these considerations? That the measure of life is service. That the thought of life should be not what can I get out of it, but what can I put in?

The Garden of Life

Authors many times and in beautiful ways have likened the garden with its flowers, to our world with its people. Have you ever stopped to consider how striking that simile may be, and how forcefully its lesson may be driven home to us? In the garden we find flowers deriving their nutriment from the soil, from the water, and from the air. What is their life; their purpose in life? To give of their beauty and fragrance that God may be honored and man's life made brighter. They give and continue to give, until life for them is no more. But in that same garden weeds will grow; weeds that spread and sap their nourishment from nature. And what does the weed give in life? Nothing. It is a troublesome plant, obstructing the flowers in the fulfilment of their purpose.

In the field of life, where weeds and flowers spring up in the natural order of things, there grows no more beautiful flower than the true nurse, her profession founded upon a love for humanity and glorified by Christ in the ministrations of His life. Hers is the opportunity for the exercise of womanly qualities in a scientific manner for the relief of suffering.

[1]Presented before the Iowa State Association of Registered Nurses, meeting in Des Moines, November 18th, 1924.

Medicine, at least as an art, had its origin to a certain extent in antiquity. Nursing as a profession came into being only after the lessons of the Master had enlightened the world. It had its birth in dignity, after medicine had separated from the veil of mysticism.

The medical lore of a very remote past was handed down from generation to generation by the Egyptian priests, the overseers of the general welfare of the people, to become ultimately known at least in part, to Hippocrates and other Greeks of the Periclean age.

The written records that have come down to us through the ages, reveal that therapeutics and religious superstition were mutually inclusive. The first medicine man was the priest. The common belief was that the cause of disease was the malice of a demon, the justice of an avenging god, the ill will of an enemy, or the anger of the dead. On account of the conservatism of the priest-physicians, Egyptian medicine never advanced far beyond primitive medicine with its simple faith in magic spells, and the virtue of a rich pharmacopeia.

The Positive Science of Prevention

It is said that self-preservation and conservation of life are the first laws of nature. To attack an invader is always more difficult and disasterous to the host than to strike the enemy dead before an entrance has been gained and damage done. "An ounce of prevention is worth a pound of cure" is an early aphorism from the mind of man. Scientific medicine, with its advancing knowledge of the causes of disease and the study and control of those causes, has given us the new field of scientific preventive medicine.

Though the science of preventive medicine is relatively new, the thought of preventive medicine is as old as the records of man. We find in the most ancient writings that the priest-physicians offered sacrifices that the evil spirits might be appeased and that their wrath might not descend in the form of disease.

Preventive medicine is a positive science. It seeks first to prevent the entrance of a disease into a country, into a community, and into an individual. It seeks to prevent the spread of disease. It searches out the causes, both immediate and mediate, endeavoring to stamp out or control them, and to build up resistances that may counteract effectually. Preventive medicine is developing in direct proportion to the growth of our knowledge of the causes of disease and the agents that may combat them. It has become a most important

topic today, descending from the realm of theory to make of itself an essential part of our every-day lives.

Our government has already recognized this fact, as medical educators are doing. The nursing profession should consider it most seriously.

Government appropriations in different departments encourage the study of preventive medicine. Yes, the importance and seriousness of the subject have impelled our government to go further. At frequent intervals the medical educators are urged to establish in their schools, courses on this subject of prevention. Every encouragement is offered to this end; the most recent action has been for the government to list in a catalog of its own, the schools in the United States which are offering specific courses.

The medical student and the nurse should look upon preventive medicine as an essential part of the curriculum which they will carry into the world and employ in the conduct of their professional work. While specialism is a desirable thing, and we thank God for the specialist who enters the field, still we must remember that the practical lessons of preventive medicine enter into the every-day life of the physician and nurse just as do the lessons of anatomy, physiology, and bacteriology.

The Nurse and Progress in Prevention

Nursing is a progressive profession and in order that the best service may be given to the patient and his contacts, the community, I would like to urge that you give serious consideration and deliberation to this subject. See if you do not come to think as I do, that some stress should be laid upon it in the curriculum of the nurse. Whether this should be at present by a group of separate lectures, or by the introduction of the subject into the appropriate parts of the curriculum, I am not decided. In our own medical school this latter plan is employed.

The nurse engaged in private duty in the home has more opportunity than any other person, to inculcate and spread the doctrine of preventive medicine. In the home the nurse is looked upon as a person of education, particularly trained in the field of medicine. She is in constant association with the patient and with members of the family. What she says is listened to and her advice is heeded. Since her contact covers the twenty-four hour period her opportunities are manifold. Fundamentally she must know how to keep herself from becoming infected, and how to prevent infection from contaminating the environment.

In practical instruction there is only one point I would like to emphasize. In some hospitals there exists an out-patient department, or else through some arrangement with the training school opportunity is offered to give the student nurse training in this field of work. Where such a condition exists I believe that part of her instruction should consist in trips to the home with the social worker, where the young nurse may study home conditions and learn the methods of adjusting environments. Woman's natural intuition, together with her acquired psychology as a nurse, will then accomplish all that we can anticipate at present in the field of preventive medicine, and open, undoubtedly, new channels for activity.

REV. JOHN RUMELY DIES

Rev. Father John Rumely, spiritual director of the Indiana State Conference of the Catholic Hospital Association, died January 13th in the Holy Family Hospital of La Porte, Indiana, where he had been ill for fourteen weeks. Father Rumely was thirty-eight years old.

Attended by a guard of honor, the body lay in state in St. Joseph's Church of La Porte, where the impressive Office of the Dead was chanted, and funeral services were held. Solemn requiem high mass was celebrated by the pastor of the church, Rev. Father I. F. Zircher, in the presence of many clergy and laymen, among them the brother of Father Rumely, Dr. E. A. Rumely of New York City. Interment was in St. Joseph's cemetery, La Porte.

At the time of his removal to the hospital, Father Rumely was pastor of St. Joseph's Church in Mishawaka, Indiana, to which he had been assigned in June, 1923.

On the completion of his theological studies, he had served as assistant in St. Mary's Church of La Fayette, until his transfer in 1917 to Holy Angels' Church in Gary, where he was also the chaplain at Mercy Hospital. This was his work until 1923, when he went to Mishawaka.

Father Rumely has furthered the movement for better hospitals. He has actively participated in the organized effort to hasten the spiritual and scientific progress of the profession, lending to its purpose the influence of his exemplary character.

MISERICORDIA APPOINTS OFFICERS

The annual meeting of the medical board of Misericordia Hospital, 531 East 86th street, New York City, with the executive board and the board of trustees, was held on the afternoon of January 27th. The following officers were appointed for the year 1925:

President—Dr. Alexander H. Schmitt (third term).

Vice-president—Dr. Ernest Fahnestock (third term).

Recording Secretary—Dr. Joseph A. Devlin (second term).

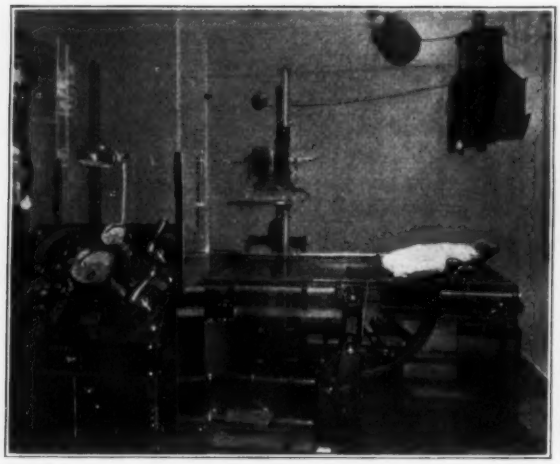
Corresponding Secretary—Dr. Frederick-Emil Neef (second term).

Treasurer—Dr. Francis Butler (second term).

The monthly conference held February 10th consisted of an executive session, a scientific session, and lectures on "Residua and Sequelae of Epidemic Encephalitis" (illustrated by moving pictures), and "Some Familiar Forms of Nervous Diseases" (illustrated by moving pictures), the latter by S. Philip Goodhart, M. D., Professor of Clinical Neurology, Columbia University, and of Nervous Diseases, New York Polyclinic.

Pathology for Nurses. By A. V. St. George, M. D., Lecturer in Pathology, Bellevue Training School for Nurses. Cloth, 228 pages, illustrated. The Macmillan Co., New York, 1924.

Staff Meeting. A meeting of the St. Francis Hospital Staff of Freeport, Ill., was held at the hospital on Wednesday, December 10. Those taking part in the program of the evening were L. G. Voigt, N. C. Phillips, E. E. Shelley, and Sarah E. Hewetson.

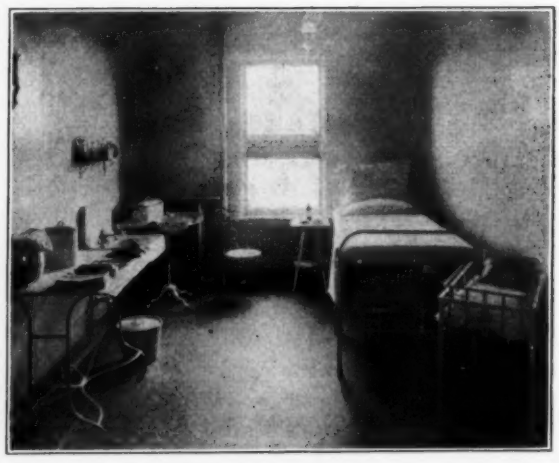


RADIOGRAPHIC ROOM.

PRIVATE ROOM.

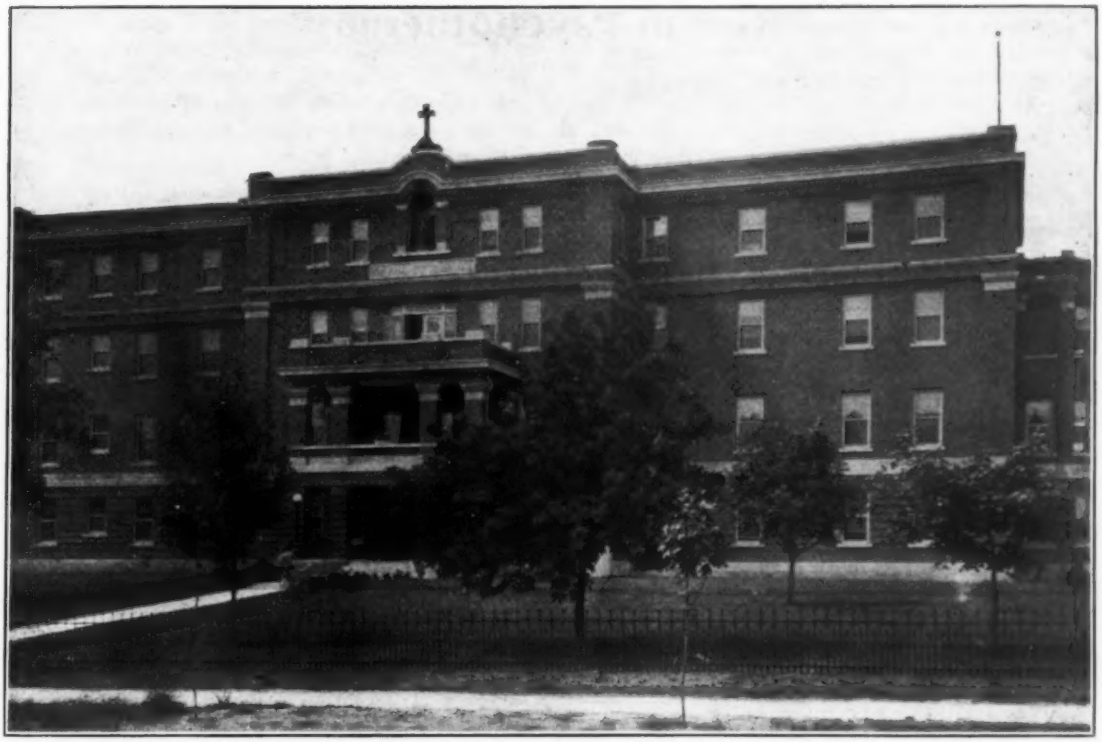
OPERATING ROOM.

PARLOR.



DELIVERY ROOM.

VIEWS OF ST. FRANCIS HOSPITAL, ESCANABA, MICHIGAN.



EXTERIOR VIEW OF ST. FRANCIS HOSPITAL, ESCANABA, MICH.

Hospital Sisters Celebrate Their 41st Year in Michigan

The eighty-five-bed St. Francis Hospital of Escanaba, Michigan, on February 12th observed its forty-first year of service under the management of the Sisters of the Third Order of St. Francis.

These Sisters were conducting a large general hospital at Peoria, Illinois, when they were asked to assume charge of the Delta County Hospital in Escanaba, and on February 12th, 1884, five members of their order undertook the responsibility of its management. It was not until October, 1913, that the Sisters actually purchased the hospital from the county, and planned for the construction of a modern building.

In April, 1915, the new fireproof structure was completed, walls of brick and concrete; partitions of tile; floors of reenforced concrete; corridors, toilets, kitchens, and stairs faced with marble terrazzo. It occupies a plot of ground covering a full-sized city block.

An increasingly large number of patients, laboratory tests, x-ray radiographs, surgical operations, and like services have created a demand for an addition of at least fifty more rooms.

The laboratory, installed in 1919, is in charge of a full-time technician and is a valuable aid to diagnosis.

The x-ray department, equipped the same year, has a film developing room and record room adjacent, and employs a full-time roentgenologist.

In 1923-24, 1,704 patients were cared for, an increase of twenty-seven over the previous year. The personnel includes twenty-two Sisters, and a large portion of the success that has been attained by the institution is attributed to the cooperation existing between the doctors and the management. Monthly staff meetings are held regularly, with the superior, Sister M. Alphonsa, in attendance.

Present members of the staff include Doctors G. C. Bartley, A. J. Carlson, H. J. Defnet, J. O. Groos, L. P. Groos, A. S. Kitchen, W. A. Lemire, G. W. Moll, A. F. Snyder, and J. J. Walch, A. H. Miller, Gladstone, Mich.

TONSIL ROOM, ST. FRANCIS HOSPITAL, ESCANABA, MICH.

Rest in Psychotherapy

James J. Walsh, M.D.

IF THE nurse is to be a focus of favorable suggestion, radiating good cheer and encouragement at all times, it is extremely important that she herself should have sufficient rest. Nothing so disturbs mental equanimity and poise as lack of rest. Overtiredness will spoil the cheeriest disposition and undermine the best of good will.

In the early years of nursing in this country, when there were not many trained nurses, and physicians had not as yet realized the necessity for conserving the health and strength of nurses, many of those who entered the nursing profession were permitted to secure entirely too little rest. Almost as a rule they were twenty-four hour nurses and often the demands on them were very severe. They lost much sleep during the night and did not have the chance to make it up in a continuous period during the day. No wonder many of them, strong and healthy young women at the beginning, broke down under the strain. This was what used to happen to near relatives when in the pre-trained-nurse days the burden of nursing fell on them. It was bad for them, but still worse in any prolonged illness for the patient. As the result of long experience the necessity for proper rest for nurses is thoroughly appreciated and regarded, and every nurse should take it faithfully.

There is even a little danger now that nurses may sometimes get too much rest, for though it is ordinarily presumed that one cannot get too much of a good thing, and rest is surely a very good thing, there is no doubt that more than a definite amount of rest does harm rather than good. Everybody under thirty should have about eight hours of sleep or at least of lying down, and while a good many people over thirty may feel quite rested with somewhat less than that, the old-fashioned division of time that comes to us from King Alfred and even earlier, eight hours for work, eight hours for sleep, and eight hours for the necessities of the body and for recreation, is still the ideal distribution of the day.

To Cure That Tired Feeling

On the other hand, those who take more rest than that, unless in very exceptional cases where there is by idiosyncrasy a special need for sleep, are probably doing themselves harm rather than good. But very few nurses with this peculiarity survive the trying time of probation and student nurse hospital work. A great many of the nervous patients who frequent neurologists' offices are among these over-resters. Most of them are in bed nine, ten, or even more hours a day, and yet their deepest and most frequent source of complaint is that "tired feeling." They are mistranslating their sensations. They have a definite feeling of discomfort in connection with exertion, but that is not tiredness, only the craving for exercise. People who awake "tired" in the morning, are usually those who are not doing hard work, and particularly those who are not getting outside much.

I have often had business men tell me that they were waking up in the morning feeling so tired that they scarcely wanted to get up. They felt that somehow they must need more rest. I have sent them away into the Adirondacks or the Canadian woods, where they got up at five in the morning to do shooting and fishing; had them trudge all day across mountains or along streams, often through forests where there were no broken paths, to come home to camp in the evening tired almost to death, sleep out in the open for eight or nine hours, and awake feeling thoroughly refreshed. Their tired feelings disappeared just as soon as they got enough exercise.

Children Awake Refreshed

Children are the typical examples of feeling ready for the day when they awake. I need not say to nurses, however, that children do not spare themselves and that they are on the go all day long, outside just as much as possible. They awake, as a rule, earlier in the morning than their folks would like to have them, and they are prepared at once for play or whatever else may be on. Being out in the air is the most important element in the production of such healthy tiredness during the day that one sleeps well during the night and awakes feeling rested. Being in the house most of the day, however, no matter how hard one's work may be, will not prepare, as a rule, for healthy, normal sleep and that rested feeling on awaking. However, tiredness on awaking is not nearly so serious a symptom as a good many people seem to think. Certainly it is not a sign of exhaustion or of approaching nervous breakdown, but on the contrary a signal for more outdoor air and exercise and very often for less sleep than people are actually taking.

I have frequently called patients' attention to the fact that on Sunday morning when they are to get up late, they often awake at the usual time, turn over for an extra snooze, and wake up again an hour or two later not feeling so well as they did on first awaking. Sunday with its late getting up and long sleep of the night before, is for a great many people the most tiresome day of the week, unless there is something very definite to do. If they sit around after breakfast reading the voluminous Sunday papers until noon or a little later, and then have a mid-day meal and a little sleep in the afternoon, by the time evening comes they are feeling perfectly miserable. It is much better for them, as a rule, to get out in the early morning, go somewhere for the day, spend most of the daylight hours outside, and then come home feeling tired but thoroughly ready for sleep at night.

Go Out When You Feel All In

I have often insisted, with nervous patients particularly, that a "played-out feeling" really meant that they were not playing outside enough, and that feeling "all in" meant that they were not going out enough. These represent only play on words, but perhaps they may cause some people to realize the true significance of feelings that are often sadly mistranslated and give their possessors very unfavorable suggestions, though they are merely nature's efforts to secure a proper amount of air and exercise instead of too much rest.

As has been very well said, rest is an extremely valuable remedy; one of the most valuable we have, especially in organic disease; but it is a dangerous remedy. It is very easy to acquire the rest habit and to take more and more of it, deeming it necessary; and all the while it is doing us harm. In this it is very much like opium. Opium is undoubtedly one of the most valuable, if not absolutely the most important remedy we have.

Professor Osler said not long before his death, that there was just one thing he would like to have carved on his tombstone — that he was an opiophile, that is, a lover of opium, of course for his patients, not for himself. And yet we all know that opium is one of the most dangerous remedies we have. Many a patient has had the opium habit produced by a thoughtless prescription of his physician. The more one knows about opium the easier it is to contract the habit. Nurses and doctors, familiar with it, fall into the habit a little oftener in proportion to their numbers, than other people. The same thing might well be said of rest.

It is sometimes thought that people who do not take a goodly amount of rest break down early in life and are quite sure not to live long. Traditions have grown up that hard workers who are always on the job, who do not take vacations at proper times and rest whenever they get a chance, wear themselves out and die comparatively young. This tradition was probably established by the "sons and daughters of rest," for it is not demonstrated by actual experience in the professions.

The Example of Doctor Emmet

Most of our greatest physicians who have lived long have been very hard workers and were especially prone to work diligently when they were young. I have told the story of Doctor Emmet's not keeping a carriage, walking to his practise, and living to be ninety-three years of age. He was an intense worker in his profession, however; otherwise he would not have made the fifty thousand dollars a year that he did some fifty years ago. He had a private hospital next to his own home, and this was before the days of the trained nurse. He had no resident physician and therefore must have been up many a night and must have been called for many a complaint that scarcely needed his attention.

Such a strenuous existence would not seem to favor the possibility of such conservation of health and strength as would give him long life, and yet he lived to be well past ninety in the enjoyment of all his powers of mind, though his body became worn out toward the end.

There is a very interestingly characteristic story with regard to Emmet which serves to show apparently how little care he took of his health, so far as the matter of hard work is concerned. He was doing some surgical work that was absolutely new, and by his methods was securing results in plastic surgery that were, in the state of surgery of that day, quite incredible. He was saving women from what would have been life-long suffering of the most serious kind, and had seemed quite hopeless of relief before his operations. This condition had come to them as a consequence of difficulties in labor, which made their apparently incurable affections all the more pitiable. Usually before this time it had been the custom to declare that such incidents were inevitable and that women simply had to stand the consequences, though they were disagreeable to the last degree since they involved urinary incontinence.

Emmet was curing these cases completely, and winning the life-long gratitude of his patients. His reputation had gone abroad and women were coming to him not only from Europe but from South America and even from distant India. Physicians visiting this country from Europe made it a point to see Emmet's work, and his name became almost a household word in medical schools. Even thirty years later, when I was a medical student in Europe, to have been a personal friend of Emmet was looked upon as a card of introduction in most gynecological and obstetrical clinics.

Emmet and His Book

One of the distinguished German obstetricians who visited this country and saw Emmet's work, was so deeply impressed by it that he said to him, "Emmet, you must write a book on this, describing your methods fully; for you are getting results that no one would credit unless they actually saw them." Emmet's reply was, "I have not the time. I am very busy with my practise and my private hospital work, to say nothing of this service here at the Woman's Hospital, so that at night no matter how much I would like to do it, I am so tired it is quite impossible for me to write. That is the only time during the twenty-four hours when I would have the leisure.

"I have tried writing at night, but it will not work. I go to sleep in my chair and I am so sleepy that I actually do not wake up until the milkman comes in the morning, or until Mrs. Emmet misses me and comes looking for me. She has refused to let me do it any more because she says, very rightly, that I do not accomplish enough to make it worth while; that sleeping on a chair is conducive neither to health nor restfulness after my hard day's work, and

that I should surely suffer from it. I have had to give up the idea, then, of writing a book."

"But you must write," his European colleague urged. "You have a message that the world needs and that would be welcomed at once. It will accomplish an immense amount of good. There are literally thousands of women in Europe suffering from these urinary fistulas and from other complications consequent upon delayed labor, who can be greatly relieved and many of them entirely cured by this method of yours. As soon as your book appears in English it will be translated into most of the modern languages.[1]

A Solution to the Difficulty

"Doctor Emmet," the European professor continued, "I had the same difficulty that you had. I wanted to write a book, and as night was the only time when I had leisure, I tried to do it then, but found, as you have, that I went to sleep over it and it was no use trying to get on. I found a way out of the difficulty. I invented a bench which I use for my writing. It is eighteen inches long, twelve inches wide, and has no back or sides. I sit on that at night and if I go to sleep I fall off and hurt myself. At least that used to happen at the beginning, but now I catch myself before I get off entirely. Then I wake up and am able to go on with my writing."

Emmet had a bench of that kind made for himself and sat on it and finished his textbook, which had a great vogue in the English-speaking countries, and as we have said in the footnote, was translated into all the important modern languages. I have often seen him sitting on this bench doing his writing when he was past eighty, and my memory is that he continued to use it even when he was past ninety. It had become a sort of second nature for him to sit on it while he was writing, and I may say that he issued three books, one of them at least in two volumes and another of them, a large octavo of some 600 pages, during the last ten years of his life. There was no exhaustion of intellectual powers, and the will to work, with the habits of a lifetime, supported him past four score and ten.

Ninety-Three Years Young

Such a practise as this would not appear to be the sort of thing that would conduce to longevity. It would surely seem to be burning the candle at both ends; working hard during the day and then using artificial means to keep awake during the night. It would quite inevitably have been expected, as far as all ordinary opinion in the matter is concerned, that Emmet would die young.

There are those who, knowing him well, have ventured to say that he did die young; he was some ninety-three years young. But even until the very end he was deeply interested in all that was going on in the world; he was intent on taking his part, especially in Irish matters; he was trying to contribute from the collection of materials that he had gathered during many years, to the body of information with regard to the relation of Ireland and England for the past hundred years; and there are some who have remarked that his collection of materials with the fearful indictment of English oppression of Ireland, had not a little to do with the revulsion of feeling which took place a few years ago and brought about that complete revolution of policy which now promises to make England's and Ireland's relations so happy for the years to come. Yet this work was all done after he was eighty-five.

Doctor Emmet's case might seem to be utterly individual and supremely exceptional, but on the contrary it is only a type of the lessons to be learned from the lives of great American physicians during the present generation. It has been taken and enlarged upon mainly because of the interest involved in the fact that Emmet's work was accomplished for women, and that his organization of the Woman's Hospital in New York was a very large factor in the introduction of the newer hospital movement.

Emmet had so trained one of his nurses, Margaret Kearney, long before the days of antisepsis, much less of asepsis, and of course years before the introduction of the trained nurse in hospital work, that he was accomplishing successful plastic surgery in that most unpromising of fields, urinary fistula. This required the securing of union by first intention under the most difficult circumstances, and yet he achieved it. He himself confessed that it was Miss Kearney's supercleanliness and her abundant use of soap and water and the simpler old-fashioned cleansing materials, that enabled him to do it.

Vitality and Longevity

There are other great physicians of this generation whose lives tell the same story as Emmet's, that intense preoccupation with professional work does not impair vitality and above all does not lessen longevity.

I have had Dr. Abraham Jacobi tell me that as a young man he used to welcome the ringing of his bell early in the morning, say at four or five, to summon him to what usually seems to a young physician a very untimely call. This would get him up early and after completing the call in an hour or so, he would not go back to bed but would stay up to read and study, catching up with the magazines and looking up the data in his textbooks with regard to cases he had seen during the past few days. He would not voluntarily have gotten up that early in the morning, but having been aroused he would not go back to bed. He would use the quiet hours before others were astir and while his own mind was at its freshest, to improve his knowledge of his beloved medicine.

Here, too, is an example that would seem to indicate that energies were being used up beyond what could naturally be supplied, and that the result would

[1]The German professor was right. When Emmet's book was issued, editions of it appeared within the next few years in French, German, Italian, and Spanish, the last, I believe, being called for particularly because of the reputation which Emmet's work upon South American patients had achieved for him in South America.

inevitably be wearing out with premature exhaustion of vitality. Even more than Emmet, however, Jacobi was young up to the very end of his life. He used to come to all our medical meetings and take part in discussions, and his opinions were valued very highly because his long experience was behind them and he had kept up very thoroughly with the progress of medicine.

Dr. Stephen Smith, of whom I have spoken elsewhere in these chapters, is another striking example of intense professional activity under the most trying circumstances and with unsparing devotion to duty, and exertion of energy. Yet he lived to be practically a centenarian. Stephen Smith is all the more interesting here because it was he who introduced the trained nurse into Bellevue fifty years ago, and this was the first training of nurses in the country. I have said that Doctor Smith never took a vacation until he was sixty, and up to that time he had been profoundly occupied with all our health problems in this country and the difficulties of hospital management that made professional practise so hard a task.

No Time for Thought of Self

Doctor Smith, like Doctor Emmett, went through a series of epidemics of cholera and typhus fever among the immigrants landing in New York harbor just after the famine in Ireland in the early fifties, and he suffered from each of these diseases. As health commissioner he secured personal information of the awful conditions in New York's tenament house district, as the almost unbelievable slums of those days were called. He himself has written the story of it in his volume, "The City That Was," and it is extremely difficult for us to understand how any one whose duty required him to be in intimate association with such work, survived the epidemics of infectious and contagious disease that were so common at that time. Certainly we would expect that exposure to such infections and the intense strain of anxiety and overwork consequent upon conscientious medical attendance on people at such times, would inevitably sap vitality. Yet Doctor Smith lived to be almost one hundred years old. (Ninety-nine years and eight months.)

When I was writing the History of Medicine in New York some years ago, there was no one to whom I could go with more confidence that his memory with regard to details of medical history would be eminently trustworthy. This was when he was past ninety. He still continued to sit on the State Board of Charities, continued to make addresses at commencements, and to lend his influence for the good of many professional movements in and around New York. The curiously interesting feature of his life is that in his early years he was looked upon as rather delicate and it was usually considered that he was not destined to live very long. Many of his professional friends were quite sure that the strenuous occupation with problems of public health to which he gave himself, was certain to break him down even before the time to which he might reasonably be expected to live.

have had Doctor Smith tell me he felt convinced that the most important factor for his longevity was his occupation with many interests, and the fact that he had no time to think much about himself. He was always so busy about other things that his own feelings were ever a secondary consideration. This was true as regards his pleasures and his eating, as well as his sensations generally. His work had become simply the principal thing in life and he gave himself wholeheartedly to it.

A Few Persistent Workers

Manifestly, then, as far as long life in a profession is concerned, intense occupation with its duties cannot be said to threaten to shorten it. I might mention many other names besides those already referred to; such men as William H. Thompson, S. Weir Mitchell, and John W. S. Goulay, who furnish ample confirmation of this. Dr. S. Weir Mitchell's name is intimately associated with the so-called "rest-cure," which of course was not a rest cure but an isolation and forced feeding cure, and it might reasonably be assumed that he would be an apostle of rest. Probably few men in the country have been such persistent workers as he. In middle life he found that trying to take a vacation of some four months in Maine with his family, for the Philadelphia custom was to go to Bar Harbor, was quite out of the question for him. He was more tired after it than at the beginning, and there was no satisfaction.

He went to Maine, then, but made it a practise to write a book every summer. He spent the morning, as a rule, at his desk, and the afternoon vacationing. It might seem as if a man who had done a good year's work at his professional duties in a large private consultation practise mornings, and long hospital hours in the afternoon, during fall and winter and spring, then wrote a book in the summer time, accomplishing what in the opinion of most authors would be another full year's work, would perhaps be doubling his activities but surely halving his length of life. Doctor Mitchell died, however, at the age of eighty-seven, and he was one of the youngest of his generation; young on to the end, a man who was confidently appealed to for poems on many medical and scientific occasions and could be depended on to make a distinct contribution to the proceedings of a medical society meeting, even at four score and five years of age.

When he acquired a tremor of the head, a sort of nodding spasm, at the age of less than sixty, most people were sure that this was a direct consequence of his intense activity. Many of his professional colleagues were prone to set it down to his trying to live two careers, that of physician and author, and wisely shook their heads another way. Even Doctor Mitchell himself was quite disturbed by this development and feared that it might represent the beginning of the breaking up of vital forces. He lived, however, for nearly thirty years more, always in the possession of his mental

faculties, a thoroughly dignified and capable figure to whom a nodding tremor added a certain hint of special wisdom.

Work But Don't Worry

There were some features besides their agreement in the matter of working hard, that characterized these men. Perhaps the most important was that they were not worrying men. It is not work but worry that kills. Taking things too hard is always disturbing. The one remedy for worry is to have so many other things to do besides whatever you are inclined to worry about, that it keeps you from giving very much attention to your worry. All of these men would have said that a man rusts out much easier than he wears out. Some of them when forced into inactivity for a time, found it very disturbing to them. They believed, like Goethe, in going on with things "Ohne Hast ohne Rast," "without haste, without rest."

Another feature of their lives was that they were all thin men; a lean horse for a long race. A man who is going to try to live as long as possible, or a woman either, must have two elements; one of them is a heritage of longevity, and the other is a lack of superabundant interest in food. If you yield to your appetite and allow your waist line to grow, you are not likely to live a long life, even though you may have good heredity. If you have not good heredity, however, no amount of care will give you longevity, though it is perfectly possible that for several generations your ancestors may have been removed from the scene early in life, by one of the many accidents of existence which have no meaning so far as regards old age and its inheritance. For after all, it makes very little difference whether a person is hit by a bacillus or a locomotive. Either may end existence at a time when there were still many years of life in store if the accident had not happened.

The Blessing of Work

There are almost no instances, however, of people of very restful ways living on to very long life. They accumulate energy for which there is no use in their ordinary occupations, and it has a tendency to be used up within themselves by a sort of short circuiting that may prove very disturbing. We have no accumulators for energy in the body. We have to use up the energies we manufacture every day in the course of that day or the next, and unless there is definite exertion of energy to secure that end we are likely to suffer from it.

Over-working is more of a myth than a reality. Nature has too many checks and brakes and modes of inhibition, even to actual inhibitory nerves, the type of which is the inhibitory nerve of the heart, for this to happen. Most of the people who suffer from nervous breakdown have not done very much hard work, and those who, like generals of armies in times of war, are put under the intense strain of solicitude and the heavy burden of responsibility which they have to bear, do not become nervous wrecks. A general of an army who became a nervous wreck would be the laughing stock not only of his army colleagues but of the world generally. We do not find them in history.

Work is a blessing in disguise. It is said to be the result of a curse of the Almighty. If when He curses it turns to a blessing in this way, it is easy to imagine what His blessings are when they are promised wholeheartedly.

The most striking example for the nurse in this respect is beyond all doubt, Florence Nightingale. Few women have ever worked so intensely as she did or amid such discouragements. During her early years she had become persuaded that she must do something serious with her life. She wanted above all to help those who needed help.

When her purpose became known to her family they were shocked that any such thought should come to her. To have occupied herself with social diversions would have seemed to them perfectly proper, but that a young woman should go out of her way to help the poor and the sick, was shocking. They simply could not understand it. When she went to Kaiserswerth in Germany in order to learn something about nursing, they were even more deeply offended. When she wanted to take advantage of the chance that seemed to be afforded her to spend some time with the Sisters in Dublin, so that she might become trained as the nuns themselves were, "For," as she herself said, "what training is there compared to that of the nun?" one of the things that she feared most was opposition from her folks at home. She wrote to Cardinal Manning in some letters that have recently been published:

"I have not my people's consent for this, and I do not think I should go without it. I was in disgrace with them for twelve months for going to Kaiserswerth." She added that her sister had been disgruntled for more than a year because of her attempt to get in touch with the deaconesses, but she felt that the experience she had gained was so valuable that it was worth even the family friction it had involved, and she was willing to take still further risks.

Long Life of Florence Nightingale

For years, without knowing it, she had been preparing herself for the great work that came to her when the awful abuses that developed in the care of the sick and the wounded in the Crimea, gave her the opportunity to show her quality and character. Any one who has ever read the account of the awful conditions which she found there, of the opposition in the midst of which she worked, and the fearful responsibilities in human life that were associated with the work, will wonder why Florence Nightingale did not grow prematurely old under the strain.

It is true that she went into seclusion after her return, and refused to take any further part in social life, though her interest in social service continued. But not a few of those who knew her best were inclined to think of this as temperamental and dispositional

rather than as representing any real pathological state. In spite of the great strain to which she was subjected, she lived to be well past ninety, and must be classed among the great nonagenerians to whom the world is indebted for some of its best work accomplished under supreme difficulties, yet without any disturbance of vitality that would shorten life.

Another striking example is to be found in the life of Clara Barton, head and principal organizer of the Red Cross. She accomplished another such great work as Florence Nightingale, and devoted herself faithfully to the most trying duties in the midst of disturbing conditions of all kinds. Yet she lived to pass her ninetieth year. Any one who realizes all that Clara Barton did for good in her time, and how the example of her work has been the basis of the wonderful power exhibited by the Red Cross for the benefit of humanity in times of crises, will appreciate very well all that she accomplished.

She did ever so much more than most women, often under a burden of solicitude and anxiety that would be supposed inevitably to provoke serious worry leading to nervous breakdown. But instead of dying young, she lived on, as so many men of similar character did, to be young even in her old age, and to go on with her work well beyond the psalmist's term of three score and ten; even beyond four score.

When the Red Cross so promptly responds to a great need like the Japanese earthquake and the incidents following it, we must not forget that the reason for that is due more to Clara Barton's organizing ability under the most trying circumstances, than to anything else. Instead of wearing herself out, she built herself up by her work, to a magnificent, productive old age.

Relation Between Work and Life

It has often been pointed out that not a few of the founders of religious orders of women who went through the most strenuous careers, have had a corresponding length of life. Very often they were little, frail women who it seemed could not possibly accomplish their self-imposed tasks, and who must inevitably break down under the burden of them. And they, too, lived on to furnish magnificent examples of how, barring accident, work does not use up vitality but on the contrary actually seems to strengthen it. They worked on until work became a habit, and habit a second nature stronger almost than nature itself, and they found intense satisfaction in their work, which encouraged them to go on often when those around them felt that it would be almost impossible for them to continue.

It is examples of this kind that are worth while having before us as illustrating the real meaning of the relation between work and life. Accidents may happen, infections may take place, and life may be impaired and shortened, but it is not work that does it, provided always the work is interesting and is not associated with worry, and provided, of course, it is accomplished with such simplicity and regularity of life and air and exercise, as assure good health during the time that it is being done.

The Development of Hospital Grounds —Planting Comments

The Last of a Series of Articles.

B. Ashburton Tripp, Member, A. S. L. A., Cleveland, Ohio.

THE planting of any grounds is but one phase of the general scheme or design. A planting, to justify itself, must fit into the arrangement in support of the other elements of the plan, in serving, as we shall find upon examination, any one or several of the following purposes:

1. A feature such as a garden, a terminus, an accent, or a mass planting.
2. A foundation planting which is the transitional step from the walls of the building to the ground.
3. A border planting which may be either a hedge or an informal arrangement.
4. A screen.
5. A background to some building, monument, or other structure.
6. A formal avenue paralleling a path, a drive, or a green, the result being the creation of a well defined vista.

Planting may easily be overdone. On the other hand, a lack of it creates the impression of barrenness. Every problem in planting, as in the case of a building project, has in it the possibility of an ideal solution. A building may be exotic in design and quite out of place in the scheme of things; yet it will stand and serve the purpose for which it was intended, provided it is structurally sound.

Planting material, however, must be indigenous to the region, or possess those qualities which will permit it to adapt itself readily to the climate and conditions to which it will be subjected. The choice of material is still further limited by its habit of growth, height, color, and season of foliage. Possessing the history and characteristics of the material available, the planting designer is prepared to create his picture, which will vary with the seasons, taking on added charm with each succeeding year, and we might add—an increased value.

Adequate Preparation

In order that any planting may be successful, much depends on the quality of the soil, and its preparation. From the point of view of economy, it is infinitely

better not to plant at all, than to plant in poor or sterile soil. It is unfair to the plants and to the structure they fail to embellish. The chief cause of so many failures in abortive landscape developments lies in a seemingly wilful evasion of one of the primary rules pertaining to the art, and that is, to omit no detail in preparation for the reception of the trees, shrubs, or flowers. False economy will always come to the surface.

Seldom do we find the natural conditions of the soil, both as to quality and depth, such as to permit planting without some form of treatment. The average natural depth is in the neighborhood of six inches. This will be found quite satisfactory for lawn areas, but where the root systems of trees and shrubs go deeper into the earth for food and anchorage, we must provide and place at a reasonable depth, the material upon which they subsist.

If there are but six inches of loam over the area to be in shrubs, we will find it necessary to strip this top-soil or loam, remove the unproductive sub-soil to a depth of a foot, and replace it with fertile top-soil. We shall then have a bed of the proper soil to a depth of eighteen inches. The preparation for trees is guided by the depth of the root system of the tree under consideration. Plants taken from nurseries are, as a rule, in a state of "suspended animation." They have been grown and prepared to meet the exigencies of such an experience, but it is quite essential that they be moved with dispatch and given careful and intelligent attention both during and subsequent to their transplanting.

To Aid Fertility

It is well to give the natural soil an application of whatever form of fertilizer will prove most advantageous to the plants' welfare. A good gardener, and one familiar with the local soil conditions, will readily recognize the needs. If there is any doubt, recourse may always be had to one of the state agricultural stations. One seldom goes wrong in adding well rotted stable manure to the beds, but where it is increasingly difficult to obtain, we are forced to resort to some of the commercial fertilizers. This requires extreme caution, not only in selection, but in the quantity to be used under a given condition. One must profit by the experience of others, and thoroughly read all directions for their use. Over-fertilization defeats the purpose; in fact, it is destructive.

Some soils are porous by nature, others are high in water content and are known as "cold" soils. A reasonable amount of water is desirable and beneficial, but an excessive quantity will not fail to bring about permanent injury or death to the plants. It is important to inquire into these conditions at the outset, and if drainage is found necessary the beds should be tiled and connected with the drainage system. Invariably, in the planting of large trees the pits should be tiled.

The Task of Maintenance

While the work of soil preparation, drainage, and planting requires most careful supervision, it only marks the end of the first stage in the procedure. From the time the plants are in the ground we have before us the eternal task of maintenance. All the trees and shrubs should be cut back sharply to relieve the root systems, which have had their functions considerably curtailed by the shock of transplanting and pruning.

The plants should be frequently and sufficiently watered. This is governed by the season of transplanting, as for instance, there would naturally be more moisture required in the spring than in the fall. A mulch ground cover should be spread over the entire planting bed to hold the moisture, and if it is a fall planting a heavy mulch should be applied after the ground has had an opportunity to freeze. This prevents alternate freezing and thawing, which are detrimental to the plant. The first year or two following planting are precarious years in the lives of the shrubs and trees. They should be nursed along, pruned, and watered as their growth requires.

A Warning Against Unskilled Care

The unstudied work of a novice may undo in one season the work of years in the life of a plant. For this reason, some one in authority, with a vital interest in the welfare of the establishment, should become acquainted with the planting and the rules for its maintenance. Gardeners come and go, and not all have been found infallible.

The rules of the particular establishment should prevail over the notions of any one gardener who may delight in the opportunity to demonstrate his superior dexterity with the pruning shears or any other of his working tools. The writer knows of one institution where the happy growth of six years of planting under proper care was destroyed by the ruthless shears of a heating engineer-janitor-gardener. What he did in one week of applied butchery can never be undone. Yet this man had an idea that he was accomplishing something meritorious.

Hospital Association Names Local Physician. The Michigan Hospital Association at the annual meeting at Saginaw, January 9th, elected Dr. Stephen L. O'Brien, secretary of St. Mary's Hospital staff, Grand Rapids, president. Other officers are: Vice-presidents, Dr. W. L. Quellans of Highland Park; Miss Amy Beers of Hackley Hospital, Muskegon; and Miss L. W. Seckinger of Foote Memorial Hospital, Jackson; secretary, Dr. D. M. Morrill of Blodgett Memorial Hospital, Grand Rapids; treasurer, Miss Anna M. Schill of Hurley Hospital, Flint; and trustees, Dr. Stewart Hamilton of Harper Hospital, Detroit; Dr. T. K. Graber of Receiving Hospital, Detroit; Dr. H. A. Haynes of University Hospital, Ann Arbor; and Mrs. Kate J. Hard of Saginaw General Hospital.

Meeting of Michigan Staff. At the regular meeting on January 22nd of the medical staff of Mercy Hospital, Muskegon, Mich., Dr. William Le Fevre presented a paper on "The Use of Instruments in the Pernicious Vomiting in Pregnancy." For the entertainment of the doctors, the student nurses arranged a musicale to follow the scientific session.

Dr. George L. Le Fevre is president of the Mercy Hospital staff; Dr. Frank W. Garber, vice-president; and Dr. F. N. Morford, secretary and treasurer.

Hospital Gift. An offer of a $100,000 gift has been made by Mrs. Howard Spaulding, of Chicago, for additions to St. Anthony's Hospital on condition that a like amount be raised by popular subscription.

In Behalf of Physiotherapy[1]

Sister Mary Gregory, St. Francis Hospital, Hartford, Conn.

THAT branch of medicine which deals with the treatment of abnormal conditions is called therapeutics. Nature's own power always tends to right her own wrongs, and we should not be too ardent in our pursuit of agents which may interfere. But this does not mean that we should fold our hands and keep a "watchful waiting" for her to do her best or worst.

While we are unfamiliar with the details of all Nature's methods of reconstruction, science has made wonderful progress in the interpretation of crying needs and is able to render service of unquestioned value through the therapeutic agent known as physiotherapy.

There is considerable doubt in the mind of the average physician as to the real worth of physical measures in therapeutics. Then again, there are some who do not doubt its value but have a poor idea, or no idea at all, of the indications for its usage; others are too busy to communicate with the physiotherapist and get his assistance even when they believe it might help.

As physiotherapy penetrates into almost every branch of medicine, the diversified experience gained by general practise is a very essential training for a physician in charge of a physiotherapy department. He should be in sympathy with the constitutional measures required by the general condition of the patient, and should carefully watch for any condition which may require surgical or medical care while under treatment in his division.

[1]Read before the New England Conference of the Catholic Hospital Association, Springfield, Mass., Dec. 9th, 10th, 11th, 1924.

ULTRA VIOLET RAY OR QUARTZ MERCURY LIGHT, ST. FRANCIS HOSPITAL, HARTFORD, CONN.

WHIRL POOL ARM TUB, ST. FRANCIS HOSPITAL, HARTFORD, CONN.

Patients should be referred to this department with a full account of their history, physical, x-ray, or any other examinations made. Physicians who have sent their patients to the physiotherapist should keep track of them in this department, watch, and if necessary criticize results. They should also be taught the fundamental physical principles underlying the application of the various modalities.

Relief Through Physiotherapy

Here are enumerated at least some of the conditions in the various departments where relief brought about by physiotherapeutic measures is most marked.

In orthopedic surgery, the method of suspension and traction, which is in itself a physical measure, makes it possible for the physiotherapist to lend his assistance by the application of radiant light and heat, combined with massage and early motions of adjacent parts, acting as a preventive measure to disability.

In old fractures with disabilities, such as malunions, fibrous unions, stiffness, and edema, the radiant light and heat, whirlpool bath, massage, diathermy, and light sinusoidal current are of untold value and often prevent

MASSAGE VIBRATOR, ST. FRANCIS HOSPITAL, HARTFORD, CONN.

PHOTOTHERAPY LAMP OR RADIANT LIGHT AND HEAT, ST. FRANCIS HOSPITAL, HARTFORD, CONN.

further operative measures. As an example, it is frequently seen that non-unions and fibrous unions are stimulated to produce firm, bony callous under diathermy. For fibrous ankylosis of joints, whirlpool bath, manipulation, and sinusoidal currents are the safest and quickest means of restoring function.

Sprains and strains. The value here of immediate electrotherapy from the very onset of the injury, is in hastening the processes which under rest and immobilization occur only when Nature herself institutes physical means of their accomplishment. Radiant light and heat, slow current, first gentle and later vigorous massage, so modify the period of disability that immobilization can soon be dispensed with.

Arthritis in its acute and chronic forms of traumatic and toxic origin, is being treated with excellent results by radiant heat, diathermy, and wave current. Mechanotherapy and massage will help mobilize the stiffened joints.

Its Various Applications

Purely medical conditions, such as chronic bronchitis and certain forms of asthma, yield quite satisfactorily to the employment of auto-condensation, radiant light and heat, also ultra-violet ray.

The neurologist will find the help of electro-therapy, massage, and exercise invaluable for the restoration of function in infantile paralysis and peripheral nerve lesions. Contrary to popular belief, functional cases of nerve diseases do not constitute the main playground of electrotherapy. Cases of neurasthenia, hysteria, and insomnia are, however, favorably influenced by these measures, if combined with proper constitutional treat-

MULTIPLEX SINUSOIDAL OUTFIT, ST. FRANCIS HOSPITAL, HARTFORD, CONN.

MORSE WAVE GENERATOR, ST. FRANCIS HOSPITAL, HARTFOED, CONN.

PORTABLE DIATHERMY FOR AUTO-CONDENSATION TREATMENT.
ST. FRANCIS HOSPITAL, HARTFORD, CONN.

ment. Neuritis will yield to physiotherapy if at the same time the exciting cause can be removed.

One could go on almost indefinitely illustrating various other types of cases which might be benefited through the coordination of the various departments, but it is only through the appreciation of the surgeon and medical man, of the available physiotherapeutic means at his disposal, that the desired satisfactory results may be accomplished.

From experience, it might be said that physiotherapy has won such favor among the staff doctors of our hospital as to increase the number of patients from twelve to forty a day in the short period of four months, the number of patients a month being about seventy-two, and the number of treatments about seven hundred. This estimate includes house patients and out-patients. The fee paid by the out-patients is an aid to financing the department.

There should, however, be no rivalry among the distinctive forms of therapy, save that friendly emulation of methods by which each one may best serve the interests of the other in best serving the sick.

Let the Dietitian Improve Your Dietary Department[1]

Merna Monroe.

I AM assuming that most of the hospitals represented here do not have a dietitian. Rather than discuss diets before those who are not directly concerned in the preparation and the serving of special diets, I have chosen to suggest to you how you can improve your dietary department by employing a dietitian.

It seems to me that many hospitals have the wrong conception of the hospital dietitian and her duties. It is up to you, the management, to give the dietitian enough responsibilities to make her position a paying proposition for you. Remember you are wasting money when you require her to busy herself with any kind of work that cheaper labor can do as well.

Teaching nurses and taking care of special diets are not the only things your versatile dietitian can do and do profitably for you. She is the embodiment of service and of proper sanitation. She is trained to make up properly balanced menus, and should teach her patients the diet they must follow when they return home.

Your hospital is judged not only by your staff, your laboratories, and your equipment, but very largely by your courtesy, your service, and by the meals you serve. Discourtesy and poor meals drive away many a potential patient, and greatly irritate those who are under your care. As a general thing, a nurse is very little interested in the serving of trays, and consequently this becomes the most slovenly service in the whole house. A sick patient seldom eats because his food appeals to him. A tray with a dingy or soiled cover, tarnished silver, ugly, mismated china, and lukewarm, colorless, tasteless food, tempts no one. If the patient eats, it will be because he is starved to it.

Personality as an Influence

It is a well drawn fact that the spirit and attitude of the head of a department permeates the whole service. If the head or manager is courteous, neat, and punctual, soon every employee under her direction is doing her very best to have things just right.

Of all the hospital personnel, the dietitian is without doubt the one person who should be at the head of the tray serving department. She has been out in the commercial world long enough to know that people are flattered and more easily satisfied when they receive personal attention. By visiting every patient in the house two or three times a week, the dietitian is giving personal attention. Not only does she put the patient in a better frame of mind by merely calling on him; she also learns whether he is being satisfied. If she is responsible for all the food and its service, and if she hears the complaints first hand, is it not reasonable to expect her to correct these defects at once?

The supervisor of the floor can and does listen to complaints about the food, but can she report the complaints without causing hard feelings and friction? Ordinarily it does not require much extra service to satisfy any patient. And why should we not make the patient's stay at the hospital as pleasant as possible? Of course, our biggest aim is to make him well, but why

[1]Read before the Mountain States Conference, C. H. A., Sept. 8th and 9th, 1924.

not be kind and courteous to him as we would want to be taken care of when we are sick, miserable, and grouchy?

The dietitian, I am certain, will do all she can to make the meals something to look forward to. She will not only lend her personality to her department; she will make sure that everything tastes just right; that the hot things are hot and the cold things cold.

Quality and Preparation

In order to have food taste as it should, it must be of good quality in the first place, and it must be properly prepared. Even the choicest of foods can be utterly ruined by poor preparation. Obviously, then, you must have a good cook.

Many a young husband can tell you that just because a woman is a woman, whose place is in the home, it does not mean that she is a good cook. A cook is both an artist and a scientist. In other words, a cook must first be born a cook, and then be taught to cook scientifically.

A woman cook is better adapted to cooking in small quantities, but a man who is a cook, excels in institutional cooking. Why? Because God made the capabilities of woman different from those of man, and we mortals cannot undo His creations. Woman is interested in individuals and centers her thoughts on each one. Therefore she has not the capacity to care for great numbers; neither has she the desire.

Man is not centered on individuals. He thinks of people as one group, and is thus able to care for the masses. Man likes to handle large quantities; he likes to do everything on a big scale. As a rule, woman does not. However, there are women who can cook successfully for institutions, provided these institutions are not too large. I think there are women who can cook for a hundred or a hundred and fifty, but for a greater number a chef is the more successful.

Good Chef an Economy

A good chef commands a high salary. Yet in a large institution he saves his salary by preparing and serving food that is not only good to look at, but exceedingly good to eat. If a patient is able to pay all of his expenses, he will go to the hospital where his money will give him the best. Let your hospital earn a reputation for good meals and you will have more patients who can pay. The dietitian cannot be asked continuously to hear complaints about poorly cooked food. Hire a good cook who will cooperate with her to give your patients the best.

To have the hot foods hot, and the cold foods cold, the dietitian will very likely ask for more or better equipment. You, the management, will probably say she is extravagant and that you can get along without it. You can. People used to get along without hospitals and trained nurses, but how? You know, there are just two ways of doing a thing—the haphazard, higglety-pigglety, inefficient way, and the orderly, scientific, efficient way.

When she asks for more equipment, suppose you investigate the matter with her; confer with the many reliable concerns about the merits of their goods; visit other modern hospitals to learn how they have solved the problem; then decide whether your dietitian is extravagant or not. After you have your equipment, notice how much easier and quicker the trays are served, without all that nervous tension and spilling and breaking, or that mad rushing when things are thrown on the trays in any manner.

Sanitation

A hospital is supposed to be the model of proper sanitation, and I suppose it is for that reason that the government never gives a hospital kitchen the rigid inspection it gives to hotels and restaurants. I wish it did. I am glad to say that most hospitals keep their kitchens immaculate, yet there are many that do not. Too many hospitals have a tendency to employ cheap help, thinking it is economy. It is not. Cheap help is sometimes too ill-informed to realize what cleanliness is, or what it means, and is very often too lazy to do the work thoroughly. With ignorance and laziness, you have as a result dirty corners and crevices, greasy tables and kitchenware. Grease attracts dirt, and the two insects that thrive in uncleanliness are bedbugs and cockroaches.

The dietitian is a good sanitation inspector. For her, every corner, every crevice, every cupboard, and every drawer must be immaculate. Even the refrigerators and cooling rooms come in for their share. There must be no mold, slime, or unpleasant odor. She will insist that no decayed or partially decayed food is served to anybody, patient or employee. A human life is a human life; no matter how useful or useless, it is not for any of us here to risk a life in order to save a few pennies.

The best economy in this respect is to buy just enough perishables as we need them. If there is any food left, use it up immediately in some other way. The dietitian will so superintend the servings that there will be the minimum of food returned uneaten, because food returned from a patient's room is pure waste. The dietitian never tolerates the reserving of any food whatsoever that is returned from a patient's room, even though it be untouched.

Food and Health

Food carries disease if it has been contaminated. Buy your foods from reliable dealers whose houses are inspected by the government, and then take care that these foods are not polluted after you receive them. In other words, put everything in its proper place as soon as it is delivered. Have your storeroom clean and well ventilated, and by all means do not employ people who are diseased. Every state health department has laws concerning the health of those who work with food.

The Colorado health law says, "No employer shall require or permit any person who is affected with open tuberculosis, venereal, or other communicable diseases,

to work with food or drugs." That means that every employer must require those who apply for positions in the storerooms, kitchens, or dining rooms, to submit to a physical examination by a conscientious physician. If we require health examinations of those who work with food, how can a charitable organization give employment to those diseased people who come for treatment but can and must work for their room and board while taking the treatment? Frankly, I do not know. To me it seems that the hospital itself, and the charitable home, should be two distinct departments.

Fruits and Vegetables

Somebody has said, "How fully we are equal mentally and physically to our day's work, depends chiefly upon the food we eat." Our advice to any one in good health concerning his diet is, eat moderately of anything you like, but include in your diet plenty of fruits and vegetables, both cooked and fresh.

Why so much emphasis on fruits and vegetables? They do have little fuel value, but they are necessary as good body regulators. They give minerals to the body; they are a rich source of vitamins, which are necessary for growth and for maintenance; they overcome constipation by their bulk and by their laxative juices; and they give an alkaline reaction in the body by counteracting the acid reaction of eggs, meat, and cereals. The body tissues must be kept slightly alkaline in order that they may function properly. Then, too, fruits and vegetables are needed just for their esthetic value; they give color, variety, and character to our foods.

Many people say that fruits and vegetables are too expensive for the limited income. I think they got this idea from books published before 1920, which attempt to show the housewife how she can feed her family most economically. These said that potatoes and cereals were cheapest, fats were too expensive, meats were costly, but that we must have them to supply our protein; and that fruits and vegetables were to be indulged in occasionally.

We still admit that according to the number of calories received, fruits and vegetables are expensive. But we don't need to worry about calories for the average individual. Most Americans eat too much anyway. We are going to worry about the minerals and the vitamins, and we are now beginning to realize that we must have laxative foods to help do away with that great American complaint and root of most organic disorders —constipation.

The Patient's Menu

We are agreed, then, that the healthy person can eat what he wants, plus some fruits and vegetables every day, and he will be well fed. But what about the patient in bed? His wants are sometimes normal, sometimes very abnormal. Let the dietitian decide what he should eat. She knows how foods react under different conditions, and she knows that many patients must be tempted to eat. There are numerous things to take into consideration when it comes to making out menus, even for those who are not on special diets. For instance, do you think of these?

1. Combination of foods—have no repetition of flavor, garnish, or method of preparation. Use flavors that blend.

2. Color scheme—let there be something on the menu that has a decided color. Try to plan a color scheme, uniform for the whole meal. Have harmony of colors.

3. Consider the proportion of protein—have some one protein dish in every meal.

4. Do not have repetition from day to day and do not have a set of menus.

5. Consider the number of calories per meal—on one day do not give all succulent vegetables and at another time starchy vegetables, escalloped dishes, and rich puddings. Mix them up.

6. Make the supper menus light and easily digested.

7. Do not have several sweet things or all sour foods at one meal. Provide variety in the flavor.

Is there any one more capable of making up the menus than the dietitian? Her whole profession is wrapped up in food, diets, and disease. She is constantly searching for new ways of serving food, and for the latest in scientific discoveries concerning diets. She pays just as particular attention to the attractiveness of the soft and the light trays as she does to the regular tray. She knows that it is often of great convenience to the patient if the light or soft diets are so planned that there will be no need to use both hands in eating; for instance, his toast will be buttered and cut into convenient strips.

Meals for Nurses

The nurses need nearly as much attention as the patients. Oftentimes a nurse is tired and discouraged when she comes down to the dinner table. If the meal is not the least bit attractive, she simply does not eat. And if this happens many times, she becomes undernourished and even more disheartened. She thinks, "What's the use?" and approaches her patients with the same attitude. Fortunately all patients do not depend upon a cheerful nurse for their recovery, although there are some patients who are too easily influenced by their nurses' mental attitude. We expect them to radiate health and cheerfulness, but they cannot if they are not properly nourished.

Let the dietitian help you to create a cheerful dining room. She has had some instruction in house furnishing. Keep your tableware polished, have clean table cloths at all times even though you have to change them three times a week. Serve the meals neatly and attractively. Here is where fruits and vegetables come in again; they are decorative, appetizing, and healthful.

The average nurse suffers from constipation, which, with putrefaction, causes auto-intoxication. Auto-in-

toxication destroys hemoglobin and lowers the vitality. A low red blood cell count and a constant poison cause tiredness, headache, and dizziness. The nurse feeling always tired and having a constant, dull headache, drinks from four to eight cups of coffee a day to overcome it. If a hospital is a place to restore health, why can it not be a place to preserve it? Let the dietitian plan the menus for the nurses as well as for the patients.

The night nurse must have her share of special attention. Her working hours are often longer and she seldom gets the rest through day-time sleeping that she would at night. The dietitian will plan the meals for the night nurses rather than offer them what is left from the previous noon meal. If there is no night cook, it will be necessary for the nurses to do their own cooking. It is not fair to the night nurse to expect her to care for her patients, meet all emergencies, and do a lot of cooking; neither is it fair to give her everything warmed up. The soup can be reheated without impairing its flavor to any extent, but provide a variety of meats that are easily cooked, have the vegetables and salad materials cleaned and ready to prepare, and have the dessert ready.

Dietetic Instructions

As a teacher, the dietitian must show her nurses the proper methods to employ in cooking foods, and the effect of different temperatures of heat on proteins, fats, and carbohydrates. She teaches them the why of everything. For example, a nurse under her direction knows why she should never let the water boil while she is poaching an egg.

Let the doctor instruct the nurses about diseases, but have the dietitian tell them what to feed patients. The dietitian, knowing foods and their digestion, can tell what foods to give. As a rule, a nurse knows just what to do for her patient until she has to feed him; then she is lost. Through practical work in the diet kitchen, both in cooking and in making out menus, she gains confidence and learns that after all, dietetics is not a bugbear, but the application of common sense.

The dietitian should teach the patients too. She absolutely must teach diabetics, nephritics, heart, and stomach cases. In all chronic diseases the patient has not been living right, and that usually means he has not been eating right. Unless he is taught better, he will follow the same routine when he goes home and in all probability will renew the ailment or develop another chronic disease.

The modern hospital has a room set aside where the patients assemble on foot or in wheel chairs, to hear the dietitian tell them what they should eat and how they are to cook it. We must not feel that the hospital's responsibility stops when the patient is discharged. There should be a social service department from which it can send nurses and dietitians into the homes to show people how to keep well.

Special Diets

Needless to say, the dietitian works with the physician in taking care of those who are on special diets. There are some disorders that must have a special diet, some that should have, and some that are helped by it.

The diseases that must have special diets are:

Diabetes—diet must be calculated and weighed.

Severe obesity—diet must be calculated and weighed.

Gastric and duodenal ulcer—diet must be non-irritating.

Diarrhea—anti-laxative.

Dysentery—anti-laxative and high animal protein.

Nephritis—low purin and non-irritating to the kidneys.

Edema—low sodium chlorid.

Those disorders which should have special diets are:

Auto-intoxication—laxative, no meats or eggs.

Arthritis—laxative, low carbohydrate, high fat, and normal amount of protein.

Anemia—laxative and high organic, iron, and easily assimilated protein.

Constipation—laxative.

Emaciation—high calorie and easily digested.

Fevers of long duration—high calorie.

Gastric hypoacidity—attractive, stimulating to gastric juice, easily digested protein, non-irritating.

Gastric hyperacidity—laxative, sub-acid, non-irritating, and non-fermenting.

Gastritis — non-irritating and fermenting, and easily digested.

Gastro-enterostomy—special.

Hemorrhoidectomy—low residue.

High blood pressure—low purin, low salt, and low protein.

Hyperthyroidism—high calorie, low purin, low protein, and low iodin.

Jaundice—low fat, fairly low carbohydrate, and non-irritating to stomach.

Skin diseases—simple, low salt, and low protein.

Tuberculosis — attractive, nourishing, easily digested.

Heart diseases—easily digested, non-fermenting, low fluid.

Those conditions that are helped:

Lactation.

Appendectomy—laxative and non-toxic.

Tonsillectomy—sub-acid and non-irritating.

Whooping cough—semi-solid and non-irritating to throat.

Goiter—anti-toxic, high iodin.

In conclusion, let me again emphasize that the reputation of your hospital rests upon the meals you serve and how you serve them, just as much as it does upon your x-ray facilities and your operating room equipment. And do not confine your dietitian's duties to teaching and taking care of special diets, when she can assume more responsibilities and by so doing, improve your dietary department.

ST. FRANCIS HOSPITAL, WILMINGTON, DEL.

Franciscan Sisters Open New Hospital

THE city of Wilmington, Delaware, regards with pride the new St. Francis Hospital opened by the Sisters of St. Francis on Oct. 15th.

The structure itself, occupying a spacious site which provides for expansion, suggests solidarity, strength, and neatness. A financial contribution of $100,000 was made toward its erection by the Sisters of St. Francis, whose order has assumed management in the persons of eleven Sisters, five of whom are registered nurses and are on duty in the medical and surgical departments. Twelve high school graduates are in the first class of the nurses' training school, and a waiting list has been compiled.

Planned for convenience and service, the hospital is both practical and pleasing to the eye. On the first floor are the office, record and store rooms, interns' quarters, chaplain's private dining room, nurses' dining hall, main kitchen, Sisters' refectory, pharmacy, x-ray and dark rooms, and the receiving room for accident and clinical cases, which is fully equipped for examinations of all kinds.

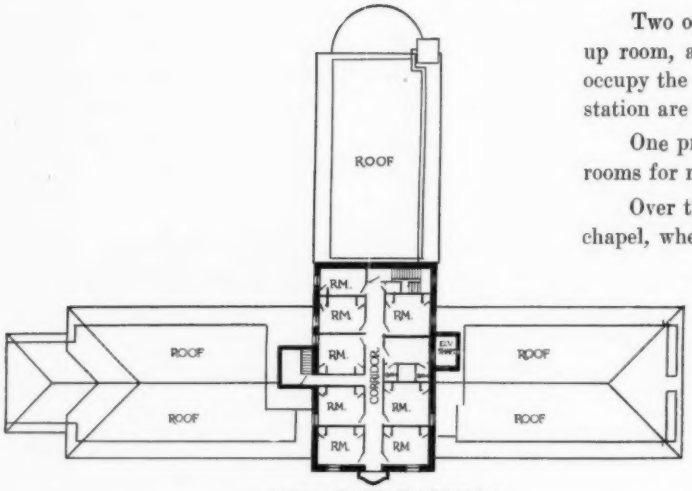
On this same floor is the ice-making and refrigerating machine, and here ice is manufactured for ice bags, etc. The ice boxes are cooled by ammonia pipes.

The kitchen is electrically equipped, and the laundry mechanically fitted out with washers, mangles, tumblers, starch boilers, pressing machine, and hand electric irons. In the sub-basement is the heating plant, providing for the vacuum return system.

The second floor, for women patients, has sixteen

WARD, ST. FRANCIS HOSPITAL, WILMINGTON, DEL.

OPERATING ROOM, ST. FRANCIS HOSPITAL, WILMINGTON, DEL.

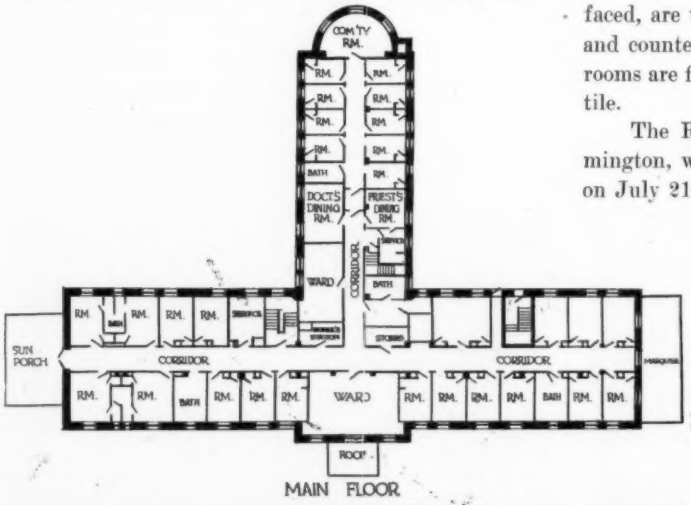


ROOF AND THIRD FLOOR PLAN

private rooms tastefully furnished with mahogany. Four of these have private lavatories and a semi-private bath. There are in this division of the hospital, a general ward of seven beds, a colored ward of four beds, a children's ward of five cribs, and a four-bed maternity ward.

In the maternity room are two racks, each containing five baskets for the infants. There are a public bath and toilet, and accommodations for thermos baths.

Sleeping, recreation, and community rooms for the Sisters occupy the rear wing on this floor. At the southern extremity is a spacious sun parlor with wheel chairs and other conveniences for the convalescent. A kitchen, with gas range and ammonia-cooled refrigera-



MAIN FLOOR

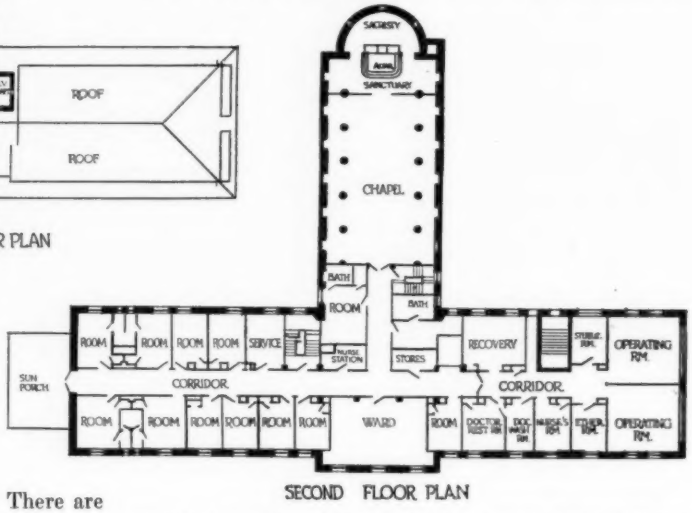
tor, is located in the center of the hall, adjacent to the nurses' duty station.

The department for men patients is on the third floor, where there are ten private rooms, four equipped for private use, as on the floor below. The general ward has seven beds; the colored ward, two. A ward for tonsil cases has three beds and one crib.

Two operating rooms, the doctors' scrub and wash-up room, anaesthesia, sterilizing, and maternity rooms occupy the north end of this floor. A kitchen and duty station are also convenient.

One private and eight semi-private white-furnished rooms for nurses are on the top floor of the building.

Over the Sisters' quarters is a small but very pretty chapel, where a temporary altar is being used until the



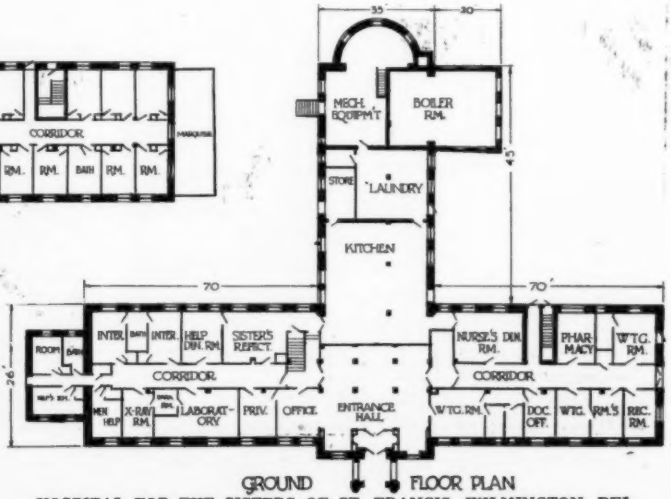
SECOND FLOOR PLAN

completion of an altar which is being made in Europe.

The new hospital was planned by Frank R. Watson, Philadelphia architect, and was erected at a cost of $270,000. The building itself is T-shaped, 191 feet long, 41 feet wide, with a 70 x 35 foot wing in the rear.

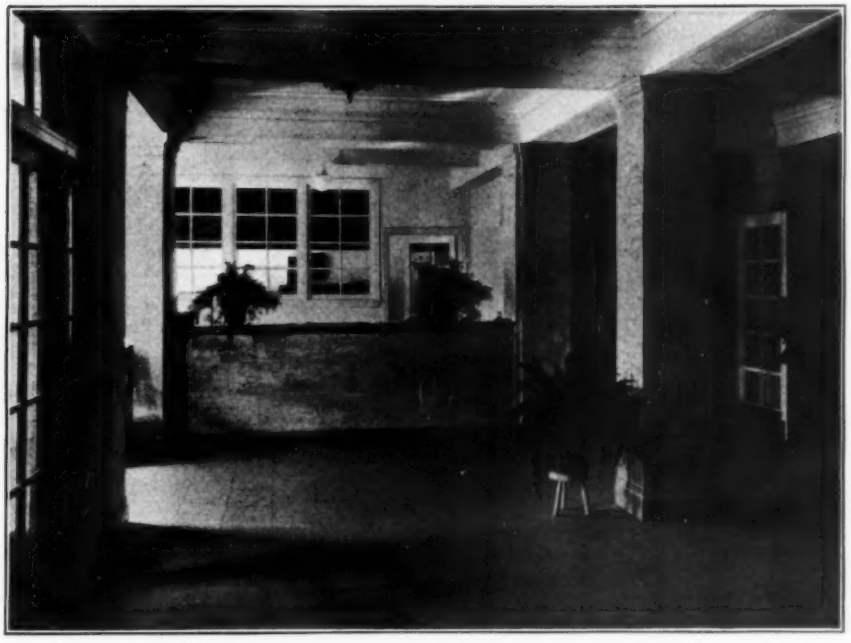
The corridor floors are of marbleloid, and those in the rooms of beech. Sanitary doors, plain, flat-surfaced, are used in all patients' rooms, and marble floors and counters make an attractive lobby. The operating rooms are finished in ceramic mosaic tile and glazed wall tile.

The Rt. Rev. John J. Monaghan, Bishop of Wilmington, who laid the corner stone of the new hospital on July 21st of last year, also conducted the dedication



GROUND FLOOR PLAN

HOSPITAL FOR THE SISTERS OF ST. FRANCIS, WILMINGTON, DEL.



LOBBY, ST. FRANCIS HOSPITAL, WILMINGTON, DEL.

ceremonies on Oct. 15th. Vicar General Mickle of Cape Charles, Va., assisted, and priests and Sisters of the Franciscan Order from other states were present.

Following the blessing of the rooms, the clergy made a general inspection of the building and were guests of the Sisters at a luncheon. Bishop Monaghan then officially dedicated the chapel by celebrating solemn benediction.

Public inspection and opening ceremonies were held Oct. 19th.

A Working Plan for Intern Service

Stephen L. O'Brien, M.D., Chief Surgical Staff, St Mary's Hospital, Grand Rapids, Mich.

IN recognition of the value of a well organized and supervised intern service as a part of our hospital organization, some important changes were inaugurated at St. Mary's Hospital, Grand Rapids, Mich., previous to the first of July. Beginning at that time, direct supervision, mapping out of the service, and checking up on the work done by the intern, were placed in charge of a resident physician responsible to the staff committee. The number of interns was increased to four, the present capacity of the hospital being 115 beds.

The intern service as established, has several features which we believe are new and valuable from the standpoint of the intern, the college from which he graduated, and the hospital.

Prior to the first of July we prepared patients' individual summary cards for each department. As soon as patients come to the registrar's office they are assigned by the resident to the intern upon whose service they enter. The resident records the patient's name, his attending physician, and the room to which he is sent. The card is then given to the intern, who from that moment on, finds on it a place to check each of his services for his patient. He carries this card with him until the patient is discharged, and by referring to it is able to tell definitely what he has done for his patient.

The hospital, by reviewing the intern's card, can also tell what he has done. It might be well to say here that we are not only able to tell what the intern has done upon any particular case; we are also able to determine what staff men give the intern something to do and cooperate with him in the diagnosis and treatment of their cases. The card, therefore, serves as a check upon the attending physician, the intern, and each patient in the hospital.

By this system of daily checking and recording the work of the intern, done as it is by the intern himself, we have at the close of the month, a summary of the total work accomplished for that entire period. The intern then makes from all the cards which he has filled out for the month, a final monthly record. These monthly records are of interest and help to us in evaluating our service.

Cooperation with Medical Schools

We believed that they would also be valuable and interesting to the various medical schools and colleges from which the interns came. We therefore corresponded with the school from which each of our house staff graduated, asking if they would be interested in

[1]Read before the annual meeting of the Michigan State Hospital Association, Saginaw, Mich., Jan. 8th, 1925, at which Doctor O'Brien was elected president.

this monthly summary regarding the intern's own record of what he was getting in our hospital. The answers were unanimously enthusiastic in favor of the plan.

Accordingly the monthly report has been promptly mailed to the dean of each school every month since July 1st, and each time the schools have replied with favorable comments upon this method and upon the type of work and training their graduates were receiving in our hospital. This briefly shows our method of keeping record of the service given by the house staff, and the opportunities offered them by the active staff.

Round Tables for Staff and Interns

In consideration of the value of close association between the members of the hospital staff and the interns, a plan was effected to hold round table discussions on the second and fourth Tuesday of each month, from 7 until 9, to discuss cases in the hospital, mortality records, and academic subjects. We believed that much could be accomplished for the hospital by such association; that the records of the various cases, prepared as they are so far as the history and physical examinations are concerned, and with progress notes on the case, and wound records by the intern, could be raised from the level of a formality to that of very accurate clinical accounts of the cases in question.

It is probable that the intern, fresh from medical school, may be eager to record pages of negative history and physical findings, only to omit possibly, or to mention merely in passing, the important and diagnostic point in an examination, while the attitude of the attending physician, on the other hand, is to seize upon the important thing only, perhaps neglecting by routine elimination, all possibilities.

It is by the harmonizing of the two extremes that these meetings make for valuable hospital records. The first accomplishment, therefore, of these round tables, is to improve our hospital records, which we believe can always be made more valuable, no matter how good they may already be.

The second thing we hope to accomplish is to furnish an opportunity for the exchange of ideas among the interns and staff men, in order to familiarize the interns with that phase of the art of medicine which is acquired only by constant contact with the public and the observation of men who have been out in the field for some time.

Their third function is to give the intern an opportunity to present the cases which he has worked up and diagnosed, and to defend his diagnosis and treatment.

Interns and Staff Meetings

In addition to the round table discussions held once in two weeks, there are regular staff meetings once each month, at which scientific programs are presented by members of the staff, and in which interns sometimes participate.

Another feature of the service which has been of considerable interest to the house staff, is the weekly meeting with the head of the department of roentgenology, who has presented much interesting material from various phases of the x-ray field.

The method of assigning and checking up the work of the intern by himself, and his compilation of the work done each month, furnish a definite estimate of the training the intern has received, not as we see it, but as he sees it; in other words, not as we see him, but as he sees us. The fact that many medical schools and several states require one year of intern service, and this in some instances before the degree of Doctor of Medicine is conferred, makes it obvious that this report of the intern's work must be of interest to the school from which he hopes to obtain his degree in medicine.

With the method adopted for checking up the work, and the close association of the intern with his patient from the time the patient enters the hospital until he leaves, the intern is not only expected to go thoroughly into the patient's history and to record his physical findings, but he immediately gets in contact with the attending physician, who cooperates with him in the treatment of the patient.

In the department of obstetrics he actively participates in the delivery of each case, and in nearly half the cases he actually conducts the labor. In the department of surgery he is an active assistant in nearly every case, and cooperates with the attending surgeon in the post-operative care. In other words, to whatever branch of the service he is assigned, in that branch he is an active participant in the service rendered the patient.

To further enhance the value of the intern service and make it as much a teaching service as possible, the round table discussions were inaugurated, and the presentation of x-ray films and discussions of x-ray diagnosis were taken up with the house staff.

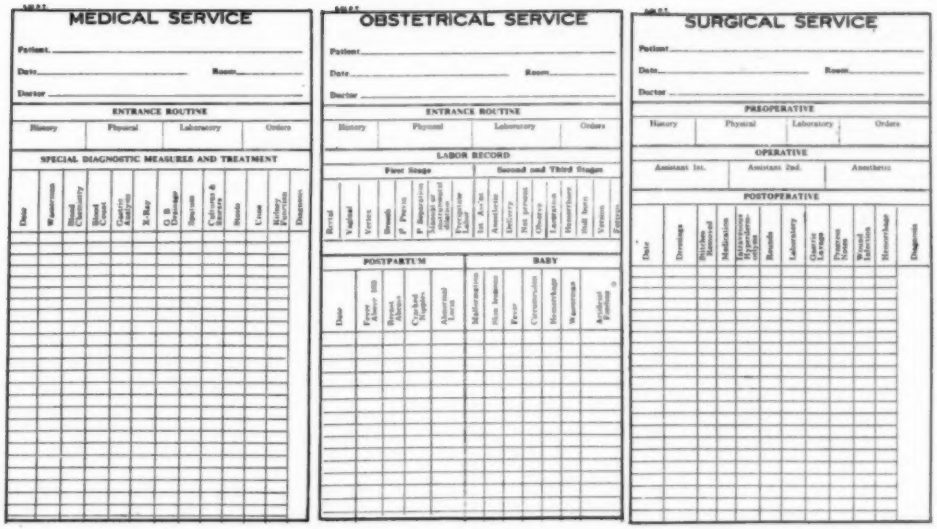
Clinical Training

Aside from an opportunity for active participation in the care of patients in the general hospital, a free clinic is maintained in connection with St. Mary's, in which clinics are held in medicine, gynecology, general surgery, goiter, neurology, psychiatry, pediatrics, and ear, eye, nose, and throat.

The service which the intern may give in this clinic is almost unlimited. The patients are semi-free cases, and after the intern has had sufficient training he is permitted, under the supervision of staff men, to do minor and in some instances major operations, and to prescribe and carry out orders under their direction.

The Interns' Monthly Records
Surgical Service October, 1924
Intern—Dr. A.

No. of patients in surgery	134
No. of histories taken	70
No. of physicals done	70
No. of operations done	72
No. of operations by intern	3
No. of operations by intern first assistant	33
No. of operations by intern second assistant	4
No. of operations intern observing	4
No. of post-operative patients cared for by intern	53
No. of intravenous and hypodermoclyses given	20



INTERN'S SERVICE CARDS, ST. MARY'S HOSPITAL, GRAND RAPIDS, MICH.

No. of emergencies	30
No. of emergency repair of wounds by intern	6
No. of cases prescribed for by intern	53
No. of deaths	5
No. of emergency deaths	1

Medical Service, October, 1924

Intern—Dr. B.

No. of patients on medical service	55
No. of histories taken	47
No. of physicals done	47
No. of cases prescribed for	55
No. of blood counts done	8
No. of sample bloods for culture	6
Sample bloods for Wassermanns	44
Sample bloods for urea	2
Sample bloods for sugar	12
Sample bloods for Widal	6
No. of urinanalyses done	4
Gall-bladder drainages	1
Intravenous treatments, vaccine, etc.	6

E. N. T.

Histories taken	5
Physicals done	5
Anaesthetics given, surgical, emergency, and E. N. T.	14
No. of operations intern first assistant (tonsil)	11
No. of operations intern operator	5
Throat smears	2

Emergencies

Histories	3
Physicals	3

Out-patient Dispensaries

No. of patients seen	18
No. of physicals done	18
No. of treatments or prescriptions given	7
Deaths	2
Autopsies attended	1
Medical patients transferred to surgery	6

Obstetrical and Pediatric Services—October, 1924

Intern—Dr. C.

No. of patients admitted to maternity	22
No. of histories taken	22
No. of physicals done	22
No. of deliveries by intern	5
No. of deliveries by intern first assistant	9
No. of anaesthetics given	6
No. of cases observed only	1
No. of cases not present for	1
No. of treatments, intravenous, vaccine	2

Pediatrics

No. of patients in children's ward	25
No. of histories taken	5
No. of physicals done	5
No. of patients prescribed for	25
No. of blood Wassermanns taken	6
No. of deaths	1
No. of stillborn	1

Clinic Pediatric Cases

Physicals done	19
Wassermanns taken	3
Pre-natal cases—physicals done	7

City Hospital Report—November, 1924

Intern—Dr. D.

Tuberculosis Sanitarium

No. of patients admitted	12
No. of patients in hospital	98
No. of histories taken	12
No. of chests auscultated	10
No. of pneumothoracies observed	15
No. of cases prescribed for	10
No. of surgical dressings	10

City Hospital (General)

No. of patients in hospital November 30th	15
No. of patients admitted	25
No. of histories taken	5
No. of physical examinations	5
No. of patients prescribed for	15
No. of Wassermanns taken	4
No. of intravenous treatments (arsphenamine and nec.) inc.	8
No. of tonsillectomies	20
No. of tonsillectomies intern first assistant	14
No. of tonsillectomies intern operator	2
No. of minor operations by intern	1
No. of major operations by intern	1

Isolation and Scarlet Fever

No. of patients in hospital November 30th	28
No. of patients admitted	18
No. of patients examined	18

Board of Health (City Hall)—Saturday Mornings 10-12

School children skin examination	35
No. of vaccinations performed	20
No. of toxins and antitoxins administered	30

Clinic for Infant Feeding—Monday Afternoons 2-5

No. of infants prescribed for and examined	30

Health Service to Employees

No. of patients examined	12
No. of patients prescribed for	10
No. of major operations performed by intern	1

Hospital Progress

EDITORIAL EXECUTIVE COMMITTEE:
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Edward Evans, M.D., La Crosse, Wis.
Edward L. Tuohy, M.D., Duluth, Minn.
Edward A. Fitzpatrick, Milwaukee, Wis.
Rev. Edw. F. Garesché, St. Louis, Mo.
William C. Bruce, Milwaukee, Wis.

MONTHLY SALARIES—PUBLICITY—HOSPITAL PUBLICATIONS

In this issue the reader will find a resumé from some of the records in the hospital in which the writer is a staff member. As indicated in a recent editorial, ordinary tabulated hospital reports gotten out on a yearly basis, do not furnish enlightening data commensurate with the difficulties involved. With present printing and paper costs, a like amount of money spent in follow-up work or more consistent use of the records themselves when tabulated, would be far more productive and beneficial to the individual hospital concerned, as well as to its friends and patrons.

Just to what degree such material may justifiably be introduced into the pages of this journal, and to what extent it may be made interesting, is a problem for all of us to work out. It is to be hoped that the number of readers of this magazine will greatly increase as time goes on. The reading matter introduced must appeal to those of diverse interests—Sisters, nurses, doctors.

Our own Father Garesché is presently compiling a most interesting booklet which we devoutly hope will in due time come to the widest distribution and use in all of our hospitals. This booklet will consider the intimate relationship of the different hospital units with the patients, not only while in the hospital but afterward.

Most people are eager to know just what is going on in our hospitals. Too often the information that leaks out vicariously deals with the bizarre, the unusual, and is gossipy rather than authentic. An attitude of suspicion may often be converted into one of strong support by simply making clear the reasons back of routine, the ultimate object of history taking, classification, follow-up, and the multitude of apparent inquisitive procedures so much a part of medical service.

It has been commented upon repeatedly, that conforming with hospital standards and filling up numerous files with records, is not the final purpose of all the agitation leading up to establishing record room facilities and insistence upon each staff member's doing his part. The time is now coming when most hospitals may assume that records are reasonably well kept and tabulated; soon we must expect that the public will be more fully instructed relative to the numerous safeguards interposed for the benefit of hospital patients.

One means of furthering this education may well be the encouragement of a much wider distribution of this journal. Father Garesché should be urged to hasten the early publication of the book mentioned, so full is it of instructive matter, building up for our sick patients a responsive instead of repellent attitude.

Medical science has still very far to go. Is it too much to hope even that we may ever come to a time when a common nomenclature will be used, not only by staff members in general but by different specialties or departments within medicine? Gradually a better understanding is developing between pathologists and clinicians; yet we have a long way to go. It is to point out in part the need of this correlation, that the autopsy material from St. Mary's Hospital, Duluth, for one month, is reported in this issue.—*E. L. T.*

THE PLEASURES AND HANDICAPS OF SIXTY-PLUS

Doctor Osler, within the memory of most of us, attained a great notoriety by saying that after forty no one did any great, worth-while thing, and quoted Trollope as saying that at sixty we should be chloroformed.

There is probably more truth in both assertions than most of us like to admit, especially when we have reached sixty-plus. Certain it is, that if our niche in life is not well established before forty, and we are not doing good, efficient work, we are not likely to do very much in a large way either before or after sixty. The exceptions often quoted only prove the rule. All of us no doubt, in our youthful heyday, planned wonderful things when leisure would come with age; but leisure never comes to the worth-while worker.

In the medical profession it is peculiarly true that we have our established place before forty. In the phenomenal advance of science, that man is a student indeed, and a healthy animal as well, who does not feel that at sixty he is beginning to be horned out of the field of real, active, scientific medicine. If he has been wise in mid-age and followed the advice of Osler in associating with himself younger men in the profession, he may still go on for ten years or more comfortably and complacently.

What is true of the individual in the medical profession, is peculiarly true of our Catholic hospitals and those conducting them. The advance in hospital management and conduct, and the viewpoint not only of the medical profession and the leaders in hospital progress, but of the laity as well, demand that we be awake to every forward movement providing for the best scientific care and the comfort of our patients. That group of hospital Sisters who "sleep at the switch," will find themselves at once Rip Van Winkles, suffering the consequences in loss of prestige and, what affects this class more, loss of clientele; so that when sixty-plus is reached, they are no longer a progressive proposition.

But the hospital Sisters who are keeping abreast of the times by frequent visits to other hospitals, by con-

stantly educating younger Sisters as under-studies to fill their places, and who are not only providing a comfortable hospital for the patient, but also seeing to it that their staff is of such caliber and character that the patient is getting the very best scientific treatment, will reap the reward that comes with the sense of duty well done, when they have reached sixty-plus.

Sixty-plus, then, need not be the point of departure for despair or apprehension, either to the medical man or the hospital Sister. It should bring to those of us who have reached that age, a feeling of satisfaction and a sense of completeness, not in the sense that our work is accomplished, but that we can and may pass on to younger and stronger hands, that work in which we have been active, and let us hope efficient, and with a feeling that we can with those younger, more active workers, cooperate in harmony for the well-being of those entrusted to our care.

Sixty-plus need not be a retiring or jumping off place; rather a sort of haven of comfort where we may enjoy with satisfaction in retrospect, and let us hope still in prospect, the accomplishment of some active work and a great deal of advisory help.—*E. E.*

THE STANDARDIZATION OF HOSPITAL PLANNING

The memorable and successful conference held on the 20th and 21st of January, at the headquarters of the Catholic Hospital Association, to discuss and better the plans for the Mary Immaculate Hospital at Jamaica, Long Island, suggests some practical reflections on hospital standardization. What is being done by the Committee on Standardization of Schoolhouse planning and Construction, of the National Education Association, might perhaps be duplicated in behalf of Catholic hospitals and of American hospitals in general.

The committee in question was organized in 1914 by the N. E. A., and its report for this year is to be issued in July. It was formed by the selection of a group of five educators and five architects of schoolhouses, all specialists in their line. The educators were versed in administration and hence interested in school planning and construction. The architects were men of long experience in the field.

The work was financed by the Rockefeller Foundation, which gave $16,000 for the purpose. Under the direction of the chairman of the committee, the actual work of study and comparison of plans was carried out by architects and architectural engineers who were employed and paid by the chairman.

This corps of workers secured and analyzed the plans of a great number of the best and most recently constructed school buildings. They noted the relative use of space in buildings, the arrangement most efficient and practical, and developed a chart called a "candle of efficiency," showing what the relative disposition of space in a model schoolhouse should be. They indicated standard layouts of rooms and departments, and the result of their work has been extremely valuable to those charged with the planning and construction of schools.

How desirable it is that a similar work be undertaken in behalf of hospitals!—*E. F. G.*

HOSPITAL FOLLOW-UP METHODS

The question has arisen, whether in carrying out hospital follow-up letters and inquiries, some confusion may not arise from similar inquiries made independently by doctors from their own offices. Such duplication of effort might introduce confusion and even antagonize the patient.

It would seem that there should be no great difficulty involved. In any case where duplication might occur, it could easily be obviated by requesting the hospital record department to extend to the physicians the courtesy of a copy of the reports they secure, in order to complete the doctors' own records. In the same manner, physicians engaged in following up both hospital and office patients along certain lines, could well cooperate by extending the same courtesy to the hospital.

In fact, this interchange of courtesies among doctors' offices, clinics, and hospitals, works out very easily and well. Too many doctors' records and histories in their own handwriting are too illegible for any one except experts long trained in disentangling their curves. Such a person is a competent stenographer.

Having records, findings, summaries, laboratory data, and all, properly copied, it is no additional effort whatever to have a good carbon made at the same time. Patients thereafter going into the hospital have with them a record equal in every way to the best (supposedly) that the clinician can produce.

For many hospitals unable to secure a suitable number of interns, this is at once a very great step toward good record making. Even when interns are present and take additional hospital histories, many other ends are met. In the first place, unless the clinician is active and alert, the intern's history will be a far better one, at least in form and structure. Unfortunately, and all too often, the intern's record will not be as accurate a reflection of the patient's true condition as the haphazard estimate of the busy but efficient clinician, arrived at in a turmoil of telephonic interruptions, but based upon a sound familiarity with clinical probabilities and pathological sequences.

Thereafter, both clinicians and interns may learn a great deal by comparing each others' records.

Before dropping this subject, let us further suggest that a variety of laboratory, operation, x-ray, or basal metabolism reports, may also be made out in duplicate. A very small, additional effort would make it possible to put them out in triplicate for the intern, who might thereby have some practical, permanent reminder of the kaleidoscopic contacts through which he wades in a modern, busy hospital.—*E. L. T.*

HOSPITAL CONFERENCE, JAN. 20 AND 21, 1925. MILWAUKEE, WIS.

Hospital Experts Convene at Call of Executives Planning Ideal Institution

At the invitation and expense of Mary Immaculate Hospital, Jamaica, Long Island, New York, a conference of hospital experts from all parts of the country was called at Marquette University, Milwaukee, Wisconsin, January 20th and 21st, to discuss and improve upon tentative plans for the new Mary Immaculate Hospital, to be erected in Jamaica by the Sisters of St. Dominic at a cost of a million and a half dollars. The meetings were promoted at the suggestion of the hospital executives, and through the cooperation of the Catholic Hospital Association and the Hospital College of Marquette University, led by Rev. C. B. Moulinier, S. J., president of the Association, and Rev. Albert C. Fox, S. J., president of Marquette University.

A liberal give and take of constructive criticism was led by Dr. Edward L. Keyes, chairman of the Mary Immaculate Hospital Advisory Board, with the aid of tentative floor plans thrown upon a white screen, and a concise, printed summary of the problems most troublesome to the administrators of Mary Immaculate Hospital.

From their own experiences and observations, the visiting Sisters, doctors, nurses, architects, and other specialists, discussed these fundamental subjects with a view to an ideal structural arrangement, ideal equipment, and ideal scientific service. In this effort the superior, Sister Eugenia, and her associates are faithfully supported by Rev. T. A. Nummey and other members of the advisory board.

Ten Stories

As explained by the architect, Mr. William J. Boegel of New York, it is proposed to move the present Mary Immaculate Hospital of ninety beds, to the rear of the new building, which will have southern exposure on the front, overlooking a city park. Girders will connect the two structures, the smaller to become eventually the out-patient department, with assembly halls, recreation rooms, etc. The site is such that as the need grows, the east and west wings can be extended to increase the bed accommodations from 350 to 650.

The general arrangement of the ten floors will be something as follows: first floor, emergency, out-patient, and miscellaneous; second, administration and consultation; third and fourth, private and semi-private rooms; fifth, maternity private rooms; sixth, maternity wards; seventh, children's wards; eighth, women's wards; ninth, men's wards; tenth, operating and x-ray rooms and laboratories.

The trend of the discussions and the general conclusions drawn are briefly outlined.

HOSPITAL CONFERENCE, JAN. 20 AND 21, 1925. MILWAUKEE, WIS.

Entrance

Is it advisable to have an entrance on a rise nine feet from the street level, approached by seventeen steps, two-thirds of which are on the outside of the building, and one-third on the inside? The object of this suggested arrangement was to provide for a spacious lobby and an imposing entrance to the chapel, which is immediately adjacent to the lobby, and directly opposite the entrance.

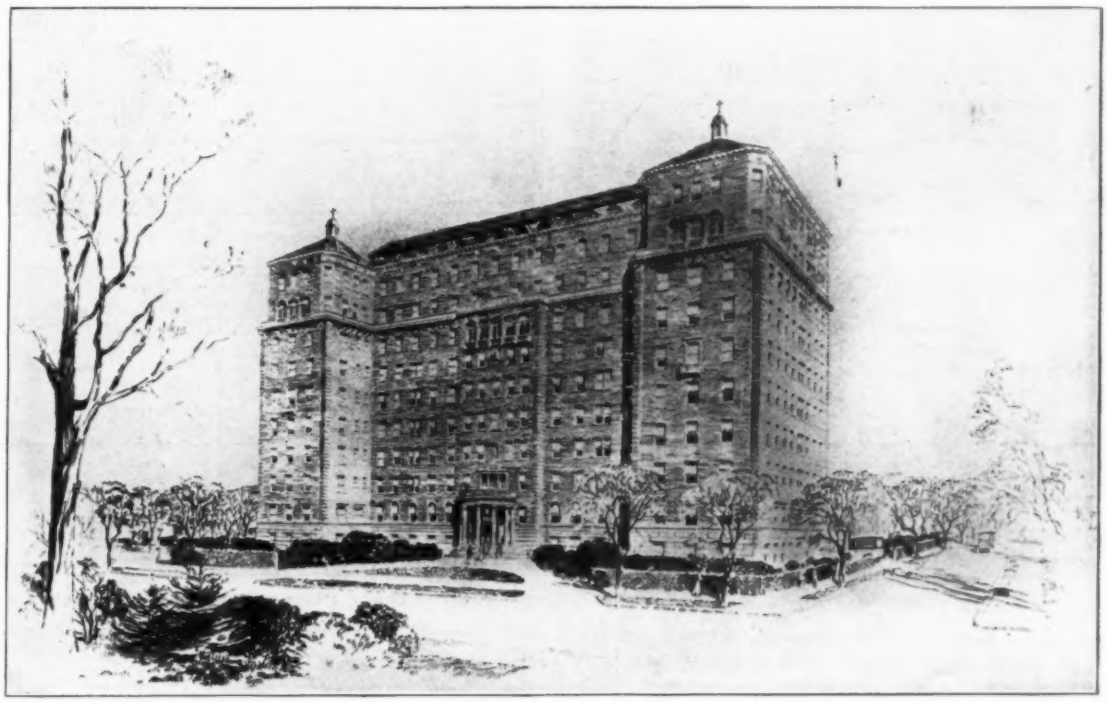
There was general disapproval of the steps, as contributing to the discomfort of the ambulatory patient. The idea of preserving this entrance for patients able to use the steps, for visitors, and so on, and of creating a separate and inconspicuous ground entrance for those requiring it, also met with disfavor, principally because it would make difficult the control of persons entering and leaving. A single, convenient entrance seemed generally desirable and practical.

hospital of sixty-nine beds, that a room twelve by twenty had been adequate for its record work since 1910, with an average of 4,100 patients yearly. Another hospital of four hundred beds has a record room fourteen by eighteen, in which records are satisfactorily filed for a period of five years, after which they are stored.

The record room of Mary Immaculate Hospital was originally but tentatively specified as forty by twenty-eight. A formal vote, however, indicated that with due consideration for the scientific importance of records, the size of the hospital, and adequate facilities for the record keepers, the delegates considered a room twenty by twenty sufficiently large.

Importance of X-ray

The location and equipment of the x-ray department were fully discussed by Dr. C. W. Geyer of the x-ray department of the Marquette University Medical School, Milwaukee.



MARY IMMACULATE HOSPITAL,
JAMAICA, LONG ISLAND, N. Y.

Wm. J. Boegel, Architect,
New York, N. Y.

Vote "No" on Cafeteria

Views were presented for and against cafeteria service for nurses. Important objections were that it encourages a hurried meal hour, little or no relaxation, an institutional atmosphere, and a laxity in the niceties of table culture.

One hospital had found it satisfactory to place the cold foods on the table and have the nurses help themselves to the hot dishes, with maids serving coffee and tea. There was, however, an almost unanimous disapproval of straight or mixed cafeteria service.

Recommend Front Rooms for Patients

It was an expression of the conference that the rooms having front exposure (southern) are far too valuable for the use of patients, to be assigned to administrative and other purposes, such as chart rooms, visitors' waiting rooms, etc. A suggestion that the chart room be in the hall was well thought of.

How Large a Record Room?

There was an extended discussion as to the proper size for the record room. It was the experience of one

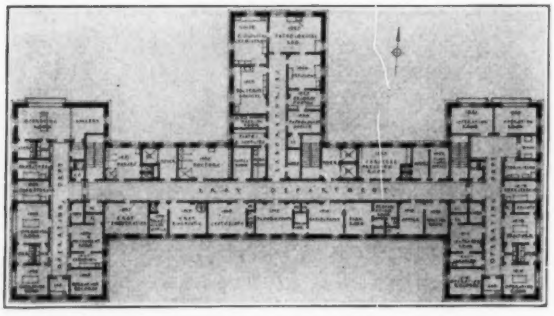
According to Doctor Geyer, an ideal x-ray department can be situated in almost any part of the hospital, provided it is large enough; that is to say, at least 3,600 or 4,000 square feet, preferably in a wing, apart from the rest of the institution, and if possible in a space nearly square.

Doctor Geyer recommended that the fluoroscopic section occupy inside rooms which are always dark, in order that the operator need not accustom his eyes to changing light, impairing his study of the details important to fluoroscopic work.

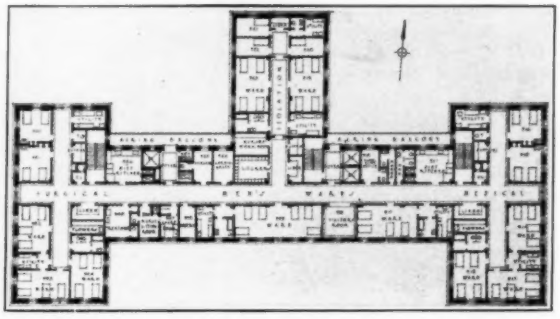
Bathing Facilities

Mary Immaculate Hospital has arranged to have two bathtubs, two Sitz baths, and two showers on each floor, a total of six.

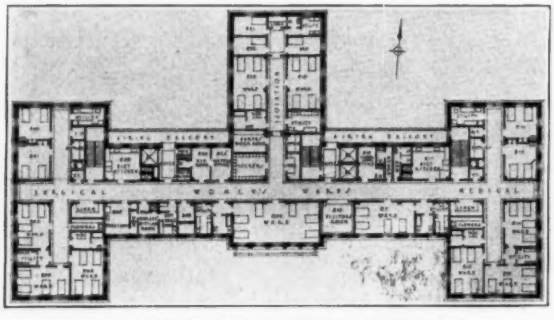
One hospital reported that a bathroom for seventeen rooms has proved sufficient up to the present time. The predominance of showers or bathtubs was regarded as a matter for local decision, but it was advised that both be provided to meet the personal inclinations of the individ-



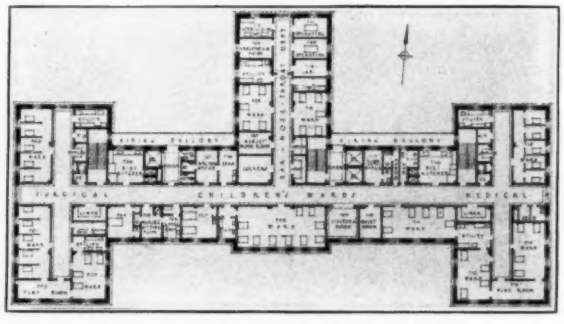
TENTH FLOOR—OPERATING, X-RAY, LABORATORIES.



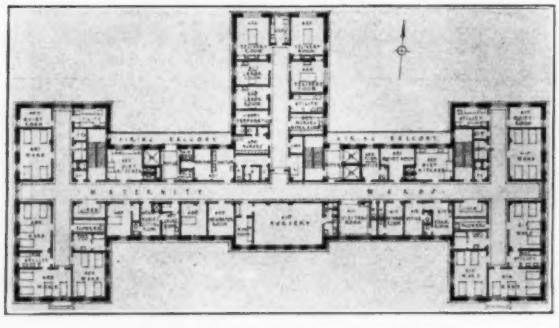
NINTH FLOOR—MEN'S WARDS.



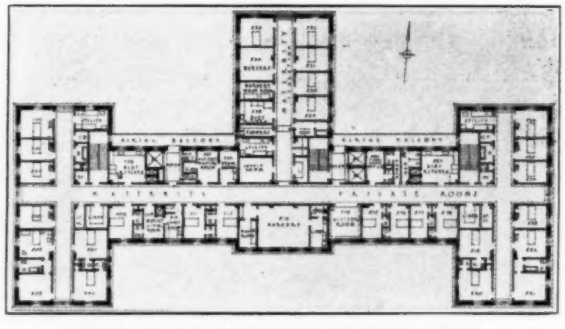
EIGHTH WARD—WOMEN'S WARDS.



SEVENTH FLOOR—CHILDREN'S WARDS.



SIXTH FLOOR—MATERNITY WARDS.



FIFTH FLOOR—MATERNITY PRIVATE ROOMS.

ual patient. Where bathtubs are used, it was urged that they be placed away from the wall, and that they be of the rolled rim type, for the greater convenience of the patient and attendant.

Maternity and Tonsil Departments

Another question on which the Jamaica hospital sought counsel, was whether two labor and three delivery rooms would be adequate for sixty maternity beds, and whether the delivery rooms should be on one or two floors. It was the opinion of the meeting that there should be four delivery rooms, located on the same floor.

Thirteen favored the general operating room for tonsil cases. Nineteen demanded a special room. One surgeon reported that the eye, ear, nose, and throat men of his hospital preferred to work in the general surgery, and a 25-bed hospital announced that it was satisfied with an arrangement of two separate operating rooms for the work of these specialists.

Operating Rooms

Out of their own experiences the delegates agreed that seventeen operating rooms, as provided in the preliminary plans, are sufficient for the needs of a 350-bed hospital, although local conditions are a determining factor. One hospital represented, found five operating rooms ample for 135-bed service. Another of 275 beds had nine operating rooms, including two for tonsil operations. Still another was satisfied with seven for four hundred beds.

The conference unanimously favored having the clean and unclean operating rooms close together; for one reason, to eliminate a duplication of anaesthetic rooms (if used), record rooms, and nurses' rooms, that could better be given to other purposes.

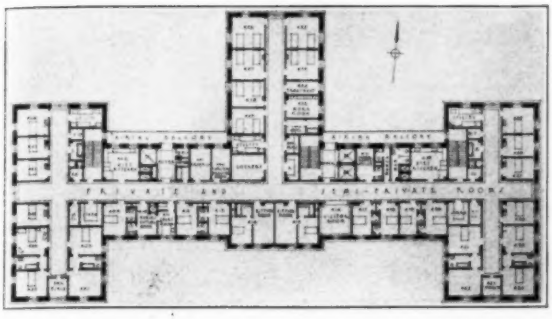
Anaesthetic Rooms

A majority of the delegates considered a separate anaesthetic room a disadvantage, inasmuch as it involves the moving of patients under ether, and saves little, if any, time. Many thought well of the suggestion that a small room be located between two operating rooms as an anaesthetic room for patients preferring not to see the surgery, and similar cases. Six hospitals represented had found it practical to have scrub and sterilizing rooms between operating rooms. None acknowledged that the arrangement was impractical.

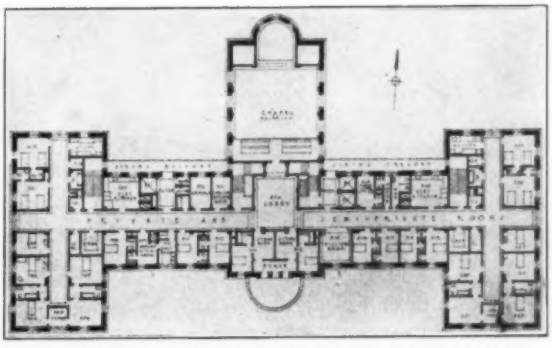
Width of Corridors

A discussion on the width of corridors indicated eight feet to be the minimum desirable, and ten the maximum. Reduction of the corridors in Mary Immaculate Hospital, from ten to eight feet, would involve a financial saving of approximately $50,000.

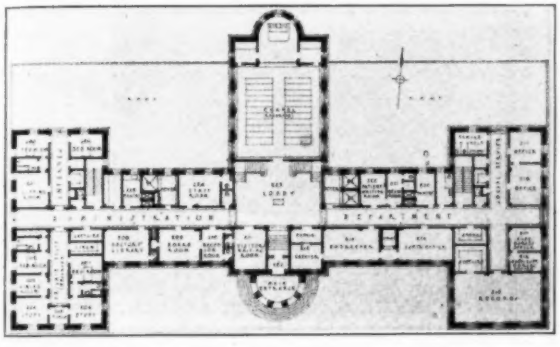
One hospital whose main corridors are ten feet wide, and side corridors eight, said it would be willing to



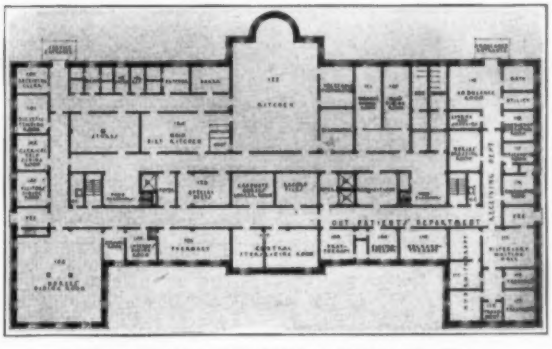
FOURTH FLOOR—PRIVATE AND SEMI-PRIVATE ROOMS.



THIRD FLOOR—PRIVATE AND SEMI-PRIVATE ROOMS.



SECOND FLLOR—ADMINISTRATION, CONSULTATION.



FIRST FLOOR—EMERGENCY, OUT-PATIENTS, MISCELLANEOUS.

reduce the ten-foot corridors to eight, for the sum of $50,000. Another with only ten-foot corridors said it would not sacrifice the two feet even for that amount. Still another hospital, in which the main hall is ten feet and the halls in the wing eight, said it had often regretted that all were not the maximum width.

Proportion of Nurses

Although it was agreed that local circumstances, the arrangement of the hospital, the number of Sisters, and so on, affect the number of nurses on duty, it was the common experience of the conference that the average number is one nurse to four or five patients.

Question of Small Laboratories

A particularly interesting discussion centered on the advisability of having small clinical laboratories for blood examinations, urinanalyses, etc., to encourage more laboratory work among the interns.

This arrangement, in the opinion of some, is less effective than a central laboratory in which the interns are obliged to do their laboratory work under supervision of the pathologist.

Others considered this phase of intern service no more important to the patient than other duties entrusted to the intern's judgment.

The suggestion that there be total supervision of the intern's laboratory work until his capacity for independent work is gauged with fair accuracy, was made with consideration for both the patient's protection and the intern's training in responsibility.

Central Sterilizing Plant

Mr. E. W. Riesbeck, mechanical engineer of Chicago, and author of a series of articles on hospital engineering problems, now appearing in HOSPITAL PROGRESS, led a discussion on sterilization, in which he expressed his disapproval of a central sterilizing plant, unless the materials are to be used very shortly after their sterilization.

One hospital which uses supplies not later than forty-eight hours after they have been sterilized, reported that in the handling of 1,800 operations in the past year, its institutional infections had numbered seven.

Mr. S. Gwyn Scanlan of the Scanlan-Morris Company, said he has concluded after twenty-five years' experience, that the sources of infection in the operating room are, first, the surgeon, then the water, then the rubber gloves. He explained that while steam at 254 degrees will unquestionably kill bacteria in a period of two minutes, the thorough sterilization of hospital supplies is, nevertheless, dependent upon the density of the bundles. The length of time required for sterilization is determined by the length of time required for the steam to reach the center of the bundles, according to Mr. Scanlan, who, with Mr. Riesbeck, advised that materials prepared for sterilization be wrapped more loosely.

The conference favored a central sterilizing plant, with the understanding that goods which have been sterilized should not be used after an interval of forty-eight hours.

Central Diet Kitchen

Speaking in favor of a central diet kitchen, Mr. Riesbeck told of two hospitals which had effected a saving of between 42 and 60 per cent by eliminating floor kitchens.

Mr. Asa Bacon, superintendent of the Presbyterian Hospital, Chicago, who has advocated the central hospital kitchen for a number of years, related that the plan has cut down the food expense of the average hospital about twenty per cent; fifty per cent in others.

Mr. Bacon considers a central kitchen necessary to the dietitian's efficient supervision of the food preparation and tray service, and finds among its numerous advantages, the elimination of cooking odors, mice, and surplus floor waste. According to the plan in operation at the Presbyterian Hospital, the nurse wishing to serve an egg-nog to her patient, takes up the receiver in the patient's room, issues her order to the kitchen, and there it is prepared and sent by dumb waiter to the particular

SOUTH VIEW, ST. BENEDICT'S COLLEGE AND ACADEMY, ST. JOSEPH, MINN.

floor, saving the nurse, perhaps, ten or fifteen minutes, which she devotes to the patient. The majority of the conference favored this central kitchen arrangement.

Organizations Present

Among those represented at the conference were: Marquette University Hospital, Milwaukee; Mt. Sinai Hospital, Milwaukee; St. Joseph's Hospital, Milwaukee; Mary Immaculate Hospital, Jamaica, Long Island, N. Y.; Mercy Hospital, Hamilton, Ohio; Good Samaritan Hospital, Cincinnati, Ohio; St. Mary's Infirmary, St. Louis, Mo.; St. Francis Hospital, Pittsburgh, Pa.; St. Mary's Hospital, Minneapolis, Minn.; St. Mary's Hospital, Duluth, Minn.; St. Michael's Hospital, Toronto, Ont., Canada; Mercy Hospital, Wilkes-Barre, Pa.; St. Mary's Hospital, Grand Rapids, Mich.; Holy Family Hospital, Manitowoc, Wis.; St. Francis Hospital, La Crosse, Wis.; St. Catharine's Hospital, Kenosha, Wis.; St. Mary's Hospital, Wausau, Wis.; Misericordia Hospital, Milwaukee; St. Joseph's Hospital, St. Paul, Minn.; Council on Medical Education, Chicago; St. Joseph's Hospital, Toronto, Ont., Canada; Oak Park Hospital, Oak Park, Ill.; HOSPITAL PROGRESS, Milwaukee.

Delegates

Delegates included: Dr. Edward Evans, La Crosse, Wis.; Mr. S. Gwyn Scanlan, Scanlan-Morris Co., Madison, Wis.; Mr. Matthew O. Foley, Hospital Management, Chicago; Mr. E. W. Riesbeck, Chicago; Mr. W. J. Boegel, Architect, New York, N. Y.; Rev. T. A. Nummey, Richmond Hill, Long Island, N. Y.; Mr. Perry W. Swern, Architect, Chicago; Mr. L. A. Brielmaier, Architect, Milwaukee; Mr. George Barkman, Architect, Hamilton, Ohio; Rev. Joseph B. Scully, Kingston, N. Y.; Rev. A. M. Schwitalla, St. Louis University, St. Louis, Mo.; Rev. Albert C. Fox, S. J., President, Marquette University, Milwaukee; Rev. C. B. Moulinier, S. J., President, Catholic Hospital Association, Milwaukee; Dr. George F. Simanek, Creighton Memorial St. Joseph's Hospital, Omaha, Nebr.; Dr. B. M. Riley, Creighton University, Omaha, Nebr.; Mr. Asa Bacon, Presbyterian Hospital, Chicago; Dr. H. W. Loeb, St. Louis University School of Medicine, St. Louis, Mo.; Dr. D. R. Joseph, St. Louis University School of Medicine, St. Louis, Mo.; Rev. E. F. Garesché, S. J., St. Louis, Mo.; Mr. Wm. C. Bruce, Bruce Publishing Co., Milwaukee; Dr. Stephen O'Brien, St. Mary's Hospital, Grand Rapids, Mich.; Dr. C. W. Geyer, Marquette University School of Medicine, Milwaukee; Dr. Edward L. Keyes, New York, N. Y.; Major Edward A. Fitzpatrick, Director of Studies, Marquette University Hospital College, Milwaukee; Rev. H. L. Fritschel, Superintendent, Milwaukee Hospital, Milwaukee.

ST. BENEDICT'S COLLEGE AND ACADEMY CHAPEL, ST. JOSEPH, MINN.

CITY OF ST. JOSEPH SELECTED FOR MINNESOTA-NORTH DAKOTA CONFERENCE

The Minnesota-North Dakota Conference of the Catholic Hospital Association will hold its third annual meeting April 14th, 15th, and 16th in the auditorium of St. Benedict College, St. Joseph, Minn.

The present conference president is Sister M. Julitta, St. Raphael Hospital, St. Cloud, Minn. Vice-presidents are Sister Conchessa, St. John's Hospital, Fargo, N. D.; Sister Adolphine, Loretta Hospital, New Ulm, Minn.; Sister M. Philomena, St. Gabriel Hospital, Little Falls, Minn. (since transferred to Marquette University Hospital, Milwaukee, Wis.). Sister M. Christopher, St. Raphael Hospital, St. Cloud, Minn., is the secretary-treasurer.

The executive board of the conference is made up of Sister Emily, St. Mary's Hospital, Duluth, Minn.; Mother Grace Aurelia, St. Joseph's Hospital, St. Paul, Minn.; Sister Boniface, St. Alexius Hospital, Bismarck, N. D.; and Sister Domitilla, St. Mary's Hospital, Rochester, Minn.

The last meeting of the Minnesota-North Dakota Conference took place in Duluth, at the Villa St. Scholastica, July 18th and 19th, 1923.

CLINICAL PATHOLOGY
Review and Digest of International Medical Literature Concerning Laboratory Technique, Laboratory Diagnostic Methods, Laboratory Apparatus etc. Edited and directed by
EDWARD L. MILOSLAVICH, M. D.
Professor of Pathology and Bacteriology, Marquette University, Milwaukee, Wis.

Mastic Reaction

(Conclusion)

Relation of Mastic Test to Gold-sol Reaction

The mastic test was perfected mainly to have a second reliable colloid reaction besides the gold-sol test. One who is used to examining many pathological c. sp. fluids, will find it very agreeable to have two dependable reactions for comparison and checking up the results of both tests in any particular case. Especially the differential diagnosis in diseases of the central nervous system can be facilitated in that way, and a more satisfactory result for both the laboratory worker and the clinician can be obtained.

To make the comparison of both tests more instructive and easier, the curves may be plotted on one chart. The five degrees of the mastic test are similar to those of the gold-sol test. The dilutions of the c. sp. fl. in the gold-sol reaction are ten times as high as in the mastic test, so that the dilutions 1:10 to 1:10,000 in the gold-sol reaction correspond with the dilutions 1:1 to 1:1,000 in the mastic reaction (see Fig. No. 5).

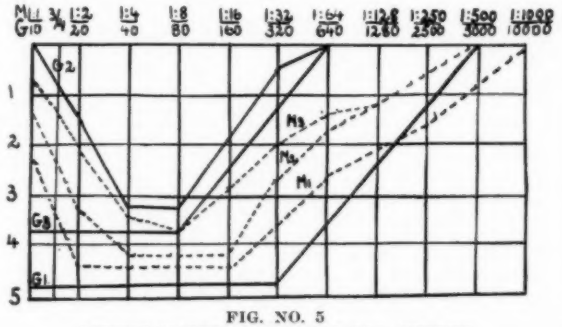


FIG. NO. 5
LUETIC MASTIC AND GOLD-SOL CURVES
Progressive paresis (M_1 and G_1)
Tabes dorsalis (M_2 and G_2)
Cerebro-spinal lues (M_3 and G_3)

The curves in the chart (see Fig. No. 5) demonstrate clearly the reactions of both tests. One can notice that the curves obtained by the mastic reaction in cases of progressive paresis and tabes are somewhat similar to each other (M1M2), while the curves of the gold-sol reaction (G1G2) show characteristic differences. The comparison of both tests is of important value, especially in cerebro-spinal lues, in which disease a definite diagnosis can be established only by using both reactions at the same time.

To make the review of the mastic test more complete, a new modification of this reaction, which was devised by Lenzberg, shall briefly be mentioned, and its principles explained.

It was attempted in a recent time to make more uniform the results of the mastic reaction and its curves in certain diseases of the central nervous system, even though mastic emulsions of different sources are used. It is expected that this may be achieved by the determination of the so-called "inhibition titer" of the mastic emulsion, using a two per cent sodium chlorid solution to which a certain amount of N50 sodium hydroxid solution is added.

Principle of the Modification

The c. sp. fl. is always diluted with a 1.7 per cent sodium chlorid solution without any alkali. The dilutions are made in the same manner as in the previously described test. The preparation of the mastic emulsion is also similar to that of the normo-mastic test.

For the new modified test every mastic emulsion may be used, assuming it does not show a sodium chlorid titer higher than two per cent. To accomplish this a certain amount of a N50 sodium hydroxid solution is added to the mastic emulsion to change its original sodium chlorid titer; namely, to obtain the titer of two per cent. The amount of sodium hydroxid solution used for this purpose is the so-called "inhibition titer." It has to be calculated by means of a preliminary titration of the mastic emulsion.

To figure the inhibition titer of the mastic emulsion, an elaborate and somewhat difficult titration of the mastic emulsion must be performed; therefore, it appears doubtful whether this modification will find its way and use into the daily routine laboratory examinations of the c. sp. fl. Besides this, the devised modification is of a recent date and its advantages over the mastic reaction described have not been tested and proved by critical controls from the side of the laboratory and clinical observers.

Diagnostic Value of Curves

The curves of the mastic and gold-sol reactions, given in this review, are not always as regular as they appear in the charts. Some of the typical curves, as they have been observed in average examinations, are presented in this paper. Occasionally some insignificant quantitative differences in the degree of the reaction may occur; slight atypical changes of the curves may also be noticed. The so-called "mixed curves" are rarely observed. But in general, the different types of curves are easy to read and to recognize, so that their diagnostic value can be utilized in practically every case.

The great majority of the various types of curves are congruous with the clinical pictures. The laboratory experience, however, has demonstrated that we should not entirely rely upon the colloidal tests alone. If occasional discrepancies should occur, one must not hasten to blame this otherwise reliable laboratory method.

We have always to keep in mind the fact that the diseases of the central nervous system show varying degrees of development and a great variety of symptoms; this is particularly true of luetic affections. The practical advantages and the success of the biological reactions of the c. sp. fl. depend largely upon a careful clinical analysis of every neurological case.

Colloid Reactions and Other Tests

The colloid reactions of the c. sp. fl. shall never eliminate nor interfere with the necessary clinical measures, but on the contrary, the more extensive and accurate the clinical examination is, the more convincing are the serological findings in such a particular case.

Undoubtedly the colloidal reactions play an important role in the laboratory examination of the c. sp. fl., but it must be explicitly emphasized that we cannot neglect the other tests. One should never draw conclusions from a single reaction, nor rely on a single test, but should use and perform other proved and dependable reactions and various tests, these laboratory procedures never to be the

only source for the establishment of an exact clinical diagnosis.

Literature: Eskuchen, K.: Mastixreaktion: Einheitstechnik and diagnostische Leistungsfaehigkeit. Klin. Woch. 45, 1924. Lenzberg, K.: Ueber eine vereinfachte Methode des NaOH Vorversuches bei der Mastixreaktion. Muench. med. Woch. 28, 1924.

J. Grill, M. D., Marquette University School of Medicine, Milwaukee, Wis., author of series on "Mastic Reaction."

STAFF CONSIDERS DIETETICS AND TONSILS

St. Joseph's Hospital staff, San Francisco, Calif., was addressed on January 14th by Sister M. Dionysia, directing dietitian, on "The Aims of the New Dietetic Department." Dietetics was declared to be a factor in preventive medicine, and food idiosyncrasy was discussed. Investigative methods described were dietary study, respiratory quotient, carbon and nitrogen determination, and calorimetric estimation, the last being stressed. All showed striking consistency. Between 2,000 and 3,300 calories daily, according to muscular exercise, were declared sufficient.

According to Sister Dionysia, construction of diet is determined by the patient's weight, height, and condition, and on a maintenance diet there is some gain in weight. Preliminary laboratory examinations and a test diet are required. Special diabetic, nephritic, and other diets are ordered by the doctor, and cared for in the diet kitchen by the dietitians. The tray is carried to the patients by the nurse in the diet kitchen, nothing being added by any Sister or nurse. The foods are weighed before and after eating.

New diet charts were explained, the principle being to individualize the dietary, as is done for each patient in any other branch of medicine and surgery. A stubborn case was quoted in which the patient could not be made sugar free until it was discovered that he was taking sugar-coated pills.

Doctors Address Meeting

Dr. R. M. Berndt presented a case history of a patient with nephritis and cardiovascular complications.

Dr. E. C. Fleischner, clinical professor of pediatrics at the University of California, spoke on "Indications and Contraindications for Tonsillectomy." He divided children into two groups, those under five years, and those over, stating that in the younger the lymphatic tissue of the tonsils is more active in developing immunity and there should be more definite reasons for removal. Redness of the anterior pillars and small granulations at the reflection of the mucous membrane from the anterior pillars to the uvula, are definite signs of disease, and disappear after tonsillectomy.

Simple hypertrophy is often nature's way of increasing the bactericidal power of the tonsil, and unless it obstructs breathing, should not prompt removal. Deep abscesses in the tonsil are indications for removal, as are also involvement of regional lymph glands and a history of diseased tonsils, malnutrition without other cause, otitis media, repeated upper respiratory inflammation, chorea, erythema nodosum, acute arthritis if teeth are good, and repeated follicular tonsillitis or quinsy.

Do not operate, ordinarily, during acute diseases, even cervical adenitis. An exception is a monarthritis if teeth are good. When the resistance is lowered by acute lesions, tonsillar infection tends to cause septicemia, while after the resistance is regained, the lesions remain localized. Endocarditis, if chronic and not due to other foci, especially with glands and acute hemmorhic nephritis following tonsillitis (after the nephritis has subsided), justifies tonsillectomy. Under five years, tonsillectomy is in order with repeated otitis media or tonsillitis, acute arthritis (monarticular), and obstruction to breathing. Simple hypertrophy, even with lymph glands, should be delayed to a later age, when the function of the tonsil is not so necessary.

Dr. Roy Parkinson opened the discussion and advised tonsillectomy for diphtheria carriers and hoarseness, comparing the merits and demerits of the operation. Dr. Ethan Smith enumerated some of the failures from it in the joint lesions. Dr. Harold Wright touched upon tuberculosis as an indication and contraindication, and Dr. E. C. French mentioned asthma with negative protein reaction, as an indication. He also reported upon St. Joseph's Hospital Clinic, and Dr. H. B. Dixon stressed its need of social service.

The program for February 11th included: "Post-operative Cardiac and Pulmonic Therapy," Dr. A. W. Hewlett; and "Treatment of Surgical Post-operative Complications," Dr. C. A. Walker.

ST. MARY'S LONG BEACH HOSPITAL STAFF HOLDS MEETING

The staff of St. Mary's Hospital, Long Beach, Calif., held its annual meeting at the hospital on Tuesday evening, January 20th. Virtually all the members participated. Dr. T. O. Boyd was unanimously reelected president, Dr. G. A. Charlton vice-president, and Dr. J. L. Wales secretary-treasurer. The president appointed Dr. J. S. Miller, Dr. A. Zetlitz, and Dr. A. E. Chase to the executive board.

Following the transaction of the regular business, two interesting papers were read by Dr. W. E. Daniels and Dr. J. W. Earel respectively.

The first was a veritable travelogue on Egypt, India, Korea, and China, with special attention to the hospital organization and care of their sick, as the speaker found them in these lands. Dr. Daniels injected a good deal of wit and humor into his address, so that his hearers found it both instructive and amusing.

The second address was on "The Dislocation of the Crystalline Lens," a very rare subject upon which, thus far, very little has been written. Dr. Earel, drawing upon his own experience and synthesizing the results of his investigation, gave a very lucid, though concise, exposition of this obstrusive subject. He illustrated the method of treatment in reviewing a case which he and Dr. S. J. Miller had recently treated with complete success.

The following doctors serve as members of St. Mary's Long Beach staff:

Dr. Ballard.
Dr. Bendlage.
Dr. Bland.
Dr. Bliss.
Dr. Boyd.
Dr. Bower.
Dr. Charlton.
Dr. Chase.
Dr. F. Clarke.
Dr. Cole.
Dr. Cole, D. D. S.
Dr. Daniels.
Dr. Dyck.
Dr. Earel.
Dr. Gordon.
Dr. Killen.
Dr. Miller.
Dr. McLandress.
Dr. Nelson.
Dr. Newman.
Dr. Plane.
Dr. Purdy.
Dr. Ramage.
Dr. Stilson.
Dr. Slaughter.
Dr. VonSchrader.
Dr. VonWedelestadt.
Dr. Wales.
Dr. Walker.
Dr. Wright.
Dr. Zetlitz.

CLEAR GROUND FOR NEW WING

Preliminary work of clearing the ground for the foundation of the first wing of the greater St. Mary's Hospital, Grand Rapids, Michigan, is well under way. The maternity and clinic quarters have been moved to new sites on the rear of the lot, to make room for the new construction.

The campaign for building funds was conducted for the purpose of raising $350,000, an amount which was finally over-subscribed by $35,000.

Architect H. L. Mead and the consulting architect, Perry W. Swern of Chicago, have completed their details and it is anticipated that the addition will be ready for occupancy in the spring of 1926.

The present hospital building has 115 beds and is in charge of the Sisters of Mercy, Sister Mary Bernard, R. N., superior. Dr. Louis Chamberlain is the acting chief of staff.

St. Mary's Hospital League recently elected new officers and listened to a discussion of the building plans, by Mr. Leroy G. Withey, vice-president of the advisory board of the hospital, who has been made chairman of the building committee. Miss Jennie A. McMahon is the league president.

The Sociability Section

Rev. E. F. Garesché, S. J.

MANY good people seem not to realize that the promotion of sociability among our young folk and the providing of innocent recreation, are charities of no mean order. Hence it is very fitting that the sodality for nurses should have a well organized and active section for the purpose of providing all the nurses with the sort of sociability and entertainment they need to keep them tuned up, so to say, for their work.

According to the time-honored proverb, all work and no play makes Jack a dull boy, and this saying particularly applies to those whose duties, like those of the trained nurse, make severe demands upon the nervous energy and patience of the worker. Recreation, sociability, and the relaxation of pleasant converse, relieve the strained nerves and relax the tense mind. It is this craving for really necessary relaxation which makes some nurses seek feverishly for excitement when they are off duty. They experience the need of relaxation and sometimes look for it in ways which really increase rather than relieve their nervous fatigue.

The consequence is that instead of being refreshed, they grow more jaded and return to their work as nerve-weary as when they left it. Members of the sociability section of the sodality should make a regular study of the things that can be done to give the nurses needed amusement and relaxation. It is their province to make continual suggestions about little entertainments and social parties which will fit in with the regular routine of the hospital.

For example, after the regular sodality meeting, the sociability section can from time to time provide light refreshments and give an amusing program of songs, instrumental music, and recitations. These impromptu parties take very little time but pleasantly vary the monotony and form bright oases in the life of self-devotion which is required of the faithful nurse.

Talent Among Nurses

There is always talent among the nurses. Some can sing or play, others act or recite, and the most agreeable entertainments are not always those which cause the most trouble in preparation. Sometimes hastily concocted dramatics or tableaux, with costumes rapidly made up from available materials, tissue paper it may be, or bunting, please the audience even more than an elaborate program. Nurses have no time to develop anything very pretentious, but in almost any hospital they can from time to time devise a pleasant interlude.

Others than the nurses may also be invited to these entertainments. The convalescent patients will appreciate them hugely, and members of the staff will like to come in at least for part of the performance. The Sisters also need some agreeable relaxation from the rigors of their work. In a word, the whole personnel of the hospital will be pleased and benefited. All this can be done with little expenditure of time on the part of the nurses, provided that the plans made are not too ambitious and that the nurses are satisfied with a moderate degree of preparation and a simple program.

Special seasons of the year will suggest particular performances. At Christmas time there may be a nativity play, when the nurses will represent some touching episode of the nativity. We have seen such performances gotten up and staged by the pupil nurses, where the costume was simple, the plot a faithful reproduction of the Bible story; where shepherds and the magi and the angels did homage to the new-born King of Kings with tuneful carols, and where every one was pleased and edified by the beauty and piety of the representation. Nurse sodalists who have taken part in these Christmas entertainments while at school, should readily manage to get one up at short notice. The pleasure given will be out of all proportion to the effort expended.

Some Suggestions

Where the local talent does not feel equal to making up the plan for such an entertainment, a number of Christmas plays offer themselves, which can readily be adapted to suit the talent of the nurses. Such performances bring the spirit of Christmas into the hospital and encourage the nurses to develop their talents. At Easter also a playlet or a mystery play can be put on, and so at other seasons of the year. By planning a little in advance and distributing the work among many, even the busiest group of nurses can manage to do something of this kind.

After the regular meetings, a short time may sometimes be found for holding a little impromptu entertainment, the program of which need not be elaborate but should be cheerful and interesting. If each is willing to do her little part for general cheer, the result will be a merry half-hour which will freshen up the spirit of the nurses more than they realize, and give the Sisters also a good laugh or a wholesome thrill of sentiment. These things may readily be arranged if the sociability committee in question is really keen for its work.

What is everybody's business is nobody's business, and unless some one is especially appointed to take care of the sociability of the nurses, many an opportunity will pass by unutilized. This is the particular advantage of having a definite group or section appointed for each activity. No one will be called on to do very much because the labor will be divided. On the other hand, the field will be pretty well covered, because each necessary activity will be assigned to definite workers.

With a little experimenting and with attention to local circumstances, there is no doubt that the sociability section will find many practical ways of carrying on its work. Sometimes a local entertainment which its members attend, may suggest to them the advisability of giving something of the same kind themselves. Sometimes they can find in books written on the subject, suggestions for playlets and interludes which they can adapt to suit hospital conditions. From time to time it will be well to have a performance for the general public, when they can charge admission, the proceeds perhaps to go for the benefit of one of the other sections.

Helping One Another

Thus the mission section, when in particular need of funds for some mission activity, may ask the sociability section to help them put on an entertainment. The committee on Catholic literature may make a similar request when it is in need of money for books. Experience has shown that such entertainments draw no inconsiderable crowd. In fact, in many places the people are considerably interested in the nurses and crowd the hall when the pupil nurses have an entertainment.

The giving of social parties and dances should also be considered a real work of zeal for young people, and this likewise comes within the province of the sociability section. A great deal is said about mixed marriages, but those who rightly protest against them sometimes forget how hard it is for young people who are Catholics to meet the right sort of Catholic society. Informal dances and entertainments of the kind, offer an excellent opportunity. It is true that the church does not wish such entertainments to be held to raise funds for religious purposes, but these informal dances will have as their purpose the promotion of Catholic sociability and not the raising of money. Funds may easily be had through other sorts of entertainment as suggested.

Especially in places where various other sodalities exist, it will be easy to secure volunteers who have talent for entertainment, to come in and give the nurses an evening's recreation from time to time. Those who can sing and play will often welcome an invitation to the hospital and think it a privilege to appear before the nurses. On some convenient evening, when many can be off duty, such a program will be in order and the staff and the convalescent patients, together with the Sisters, may be invited to share in the recreation.

Cultural Programs

Illustrated lectures on art, travel, and themes from Catholic history, may often be had at moderate expense; moreover, they help to raise the intellectual tone of the nurses and to interest them in subjects with which refined and educated persons should be familiar. The sociability section will do well to raise a fund for this purpose and to secure the services of those who can speak interestingly on cultural subjects.

In other schools occasional lectures form a regular part of the year's program and are carefully arranged for before hand. Why should not the student nurses enjoy a similar privilege? If anything, they are more in need of such lectures because they require some mental relaxation and need to be helped to a higher plane of culture, that they may have resources for self-improvement not afforded by the ordinary routine of the nursing school.

Sometimes local talent may be found which will be available for such interesting and cultural lectures. On other occasions the visit of some lecturer to the city may suggest inviting him to come and speak to the nurses. Every one, sodalist or not, may be invited, and friends from without the hospital may be notified and welcomed as far as space will allow.

Interesting the Public

There is at present too great a separation between the workers in our hospitals and the general public. These entertainments to which the public is welcomed, will serve in their way to break down this barrier and to make the friends of the hospital better acquainted with the nurses and with the hospital personnel in general.

It is true that in carrying out these suggestions it is always necessary to have in view the limitations of time and energy which the life of the nurse imposes. But with management and organization, by dividing the work and using forethought, the sociability section can do great things for the nurses themselves and promote the interests of the hospital by the true beneficence of encouraging sociability and providing entertainment.

DOCTORS' SECTION

St. Mary's Annual Meeting. The annual meeting of St. Mary's Hospital, Green Bay, Wis., was held on January 15th. The following officers were elected:

President, Dr. George Senn.
Vice-President, Dr. R. L. Cowles.
Secretary-Treasurer, Dr. A. J. McCarey.

The annual report of the hospital's activities for the past year was read and showed that the hospital enjoyed one of the most successful years in its existence. The death rate for the hospital during the year was only 1.18 per cent.

New Officers for 1925. Mercy Hospital, Janesville, Wis., elected the following staff officers for the year 1925: President, Dr. T. W. Nuzum: Vice-President, Dr. M. A. Cunningham; Secretary, Dr. S. G. Metcalf.

The executive board is composed of Dr. W. A. Munn, Dr. J. F. Pember, Dr. W. H. Palmer, Dr. Frank Van Kirk, and Dr. W. T. Clark.

Illinois Staff Elects. At a recent meeting, the staff of St. Francis Hospital in Freeport, Illinois, chose the following officers by election:

President—Dr. C. L. Best.
Vice-President—Dr. N. R. Harlan.
Secretary—Dr. G. M. Tyrrell.
Executive Committee—Dr. N. C. Phillips, Dr. J. J. Grant, Dr. C. J. Leavy, Dr. B. A. Arnold, Dr. J. S. Clark, Dr. W. B. Peck.
Publishing Committee—Dr. E. A. Diestelmeier, Dr. Lynda K. Hutchins.
Record Committee—Dr. R. J. Burns, Dr. L. G. Voigt.
Consulting Staff—Dr. J. A. Poling, Dr. W. L. Karcher, Dr. J. N. Daly, Dr. K. E. Snyder, Dr. R. C. Miller, Dr. W. J. Rideout, Dr. T. J. Holke.
Program Committee—Dr. T. A. Pettepiece.

The program at this meeting included talks by Dr. J. Sheldon Clark, "Uses of the Ophthalmoscope in Early Diagnosis of Eye Conditions as Well as Various Other Diseases of the System"; Dr. K. F. Snyder, "Varicose Veins in Various Parts of the System"; and Dr. Thomas Waggoner, "The Intravenous Method of Medication."

BREAK GROUND FOR NEW MEDICAL CENTER

Under the direction of the Joint Administrative Board of Columbia University and the Presbyterian Hospital, New York, ground was broken for the new Medical Center at 168th Street and Broadway on January 31st at 2 o'clock in the afternoon. The following program was observed:

Presiding Officer: General William Barclay Parsons, Chairman of the Joint Administrative Board.

Address: Nicholas Murray Butler, President of Columbia University in the City of New York.

Address: Dr. C. Floyd Haviland, Chairman of the New York State Hospital Commission.

Address: Mr. Dean Sage, President of the Board of Managers, Presbyterian Hospital, in the City of New York.

Breaking Ground: Mr. Edward S. Harkness, First Chairman of the Joint Administrative Board, Columbia University and Presbyterian Hospital.

Benediction: Reverend William T. Manning, Bishop of the Diocese of New York.

Invitations to the exercises were extended to the public generally.

Work will go forward immediately, as contracts for steel and for excavation have been awarded. This first unit requires an outlay of $7,000,000 for the hospital, and $3,000,000 for the medical school portion of the combined building.

This construction will be followed by the addition to the Center of maternity hospital, babies' hospital, eye hospital, ear, nose, and throat hospital, an orthopedic institution, a dermatological hospital, a urological service, a psychiatric institute and hospital, student dormitories, a residence and a school of nursing for the Presbyterian Hospital.

The development of the Center is under the direction of the Joint Administrative Board, which will represent these several institutions joining the Center. At present it consists of General William Barclay Parsons, chairman; Mr. Edward S. Harkness, Mr. John G. Milburn, Mr. Henry W. de Forest, Mr. Dean Sage, with Dr. C. Charles Burlingame as executive officer, and Dr. William Darrach, dean of the medical school, acting in an advisory capacity.